STATE TITLE V BLOCK GRANT NARRATIVE
STATE: CO
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Colorado first placed online for review and public input its FY 2000 Maternal and Child Health Block Grant in 1999. Since that time, all narratives have been placed online. Users find online access to the grant very convenient, and comments throughout the year are solicited through a return email function on the Web site.

Much input was sought for the FY 2006 grant application through the intensive needs assessment process that was conducted. This process is described in detail in the needs assessment section (Section II).

A draft version of the FY 2006 grant application was placed on the state health department's website on June 24, 2005. Comments were solicited by external reviewers and appropriate changes were made in the final grant application before the July 15, 2005 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2006 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Introduction

The Rocky Mountain state of Colorado is bounded on the east by Kansas and Nebraska, on the north by Nebraska and Wyoming, on the west by Utah and on the south by New Mexico and Oklahoma. The boundary lines create an almost perfect rectangle, measuring approximately 387 miles from east to west and 276 miles from north to south, covering 104,247 square miles. Colorado is the eighth largest state and consists of mountains, plateaus, canyons, and plains. The eastern half of the state has flat, high plains and rolling prairies that gradually rise westward to the front range foothills and the higher ranges of the Rocky Mountains. The Continental Divide runs from north to south through west central Colorado and bisects the state into eastern and western slopes. The western half of the state consists of alpine terrain interspersed with wide valleys, rugged canyons, high plateaus and deep basins.

The state can be divided into five distinctive regions within its 64 counties: the Front Range, the Western Slope, the Eastern plains, the Eastern mountains, and the San Luis Valley. Each of these areas has grown in population, ranging from a 15 percent increase in the San Luis Valley from 1990 through 2000 to a 38 percent increase on the Western Slope. Close to 82 percent of the population lives in the Front Range, which includes the metropolitan areas of Denver-Boulder, Ft. Collins, Greeley, Colorado Springs, and Pueblo. The San Luis Valley in the southern part of the state is the region with the smallest population, with about 46,000 residents. Over fifteen percent of Colorado residents are considered rural residents, living outside core urban areas and areas adjacent to an urban core. Yet, close to 40 percent of these rural residents live in the urbanized Front Range counties. The rural vastness of much of the state is confirmed by 23 of Colorado's 63 counties in the 2000 Census qualifying as "frontier counties," containing fewer than 6 persons per square mile. The mountain range separating the populated Front Range from the more rural areas of the Western Slope, Eastern Mountains, and San Luis Valley makes the delivery of health care more difficult to those in these rural areas.

In 2001, one additional county was added to the existing 63: Broomfield County consists of areas formerly in the urban counties of Adams, Boulder, Jefferson, and Weld. Each of the 64 counties within Colorado has its own local government. There are 15 organized health departments covering 24 counties. In addition, 39 county nursing services provide services to the remaining 40 counties.

Population

The population of Colorado is estimated at 4,647,321 in 2005, an increase of 346,060 since the 2000 Census enumerated the state's population at 4,301,261. Average annual growth in recent years has been 1.6 percent, down from the 2.7 rate of the 1990s, but high enough to make Colorado still one of the fastest growing states.

The two major racial and ethnic groups in Colorado are White non-Hispanic and Hispanic. In the 2000 Census, 74.5 percent of the population identified themselves as White non-Hispanic, 17.1 percent identified themselves as Hispanic, and 8.4 percent identified themselves as not Hispanic and not White. Among all racial groups (not considering Hispanic ethnicity which is generally included under White), 82.9 percent of the population was White; 3.8 percent was African-American or Black; 2.2 percent was Asian; 1.0 percent was American Indian; 0.1 percent was Native Hawaiian or Pacific Islander; 7.2 percent was some other race; and 2.8 percent were persons belonging to two or more racial groups.

The Hispanic population has grown rapidly in recent years; from 735,601 in 2000 to an estimated 876,800 in 2005. Much of the increase in the Hispanic population is made up of United States citizens and immigrants who are in the United States legally, but some substantial but unknown amount of growth consists of undocumented workers and their families who are not legal residents.

The total number of births in Colorado has also increased rapidly in recent years. In 2000 there were 65,429 births, which grew to 69,305 in 2003. The number of deaths has changed as well over this time period. In 2000 there were 27,229 deaths which grew to 29,410 in 2003. It is important to note that migration has also been an important factor in the state's population growth in recent years. Between 2000 and 2005, net migration is estimated to have added an additional 195,000 residents.

According to the 2003 American Community Survey, the Census Bureau's most up-to-date annual survey, 15 percent of children and adults spoke a language other than English. For both children and adults, Spanish was the main other language spoken with 12 percent of school-aged children and 11 percent of adults able to speak Spanish. The survey estimated that from 3 to 5 percent of households in Colorado were linguistically isolated, i.e., that all members 14 years and older had at least some difficulty with English.

Estimates by the Colorado Department of Local Affairs suggest that almost 21 percent of the population in 2005 (992,490) are women of reproductive age (15-44). Approximately 29 percent or 1.3 million are children 19 and younger. The number of women of reproductive age is projected to grow by over 10 percent in the next ten years to close to 1.1 million; the number of children in the state is projected to grow by over 15 percent in that same time period to close to 1.5 million.

Economy

With the influx of population in the 1990s, Colorado experienced an increase of over 42 percent in employment growth from 1990 through 2003, making it the 5th highest state in employment growth during that time, much higher than the national average of 19 percent. Colorado saw record low unemployment in 2000, but the economy began a downturn in 2001. The years 2002 and 2003 were recession years for the state, and recovery, beginning in 2004, has been slow. The April 2005 unemployment rate stands at 5.2 percent, compared to 6.1 percent in July 2003 and a record low of 2.7 percent in 2000.

In 2003, 9.8 percent of the population in Colorado was estimated to be living below the poverty level; 11.5 percent of children 5 to 17 and 16.4 percent of children under 5. The poverty rate for the state's largest minority population, those of Hispanic origin, was estimated at 16 percent, and one in 5 Hispanic children age 0 to 17 lived in households below the poverty level. While the American Community Survey did not estimate the poverty rate for women of reproductive age by race and ethnicity, the 2000 Census reported that 21 percent of all Hispanic women of reproductive age lived below the poverty level.

Health Care Access

Colorado ranked 37th in the proportion of residents with health insurance coverage among all states in 2003. A total of 16.2 percent of all Colorado residents and 13.7 percent of Colorado's children were without health insurance in that year; Colorado's ranking for children with health insurance coverage was 43rd among all states. Furthermore, about one-quarter of women under the age of 35 are without insurance. About one-third of women giving birth each year receive coverage for prenatal care through Medicaid; this proportion has increased in recent years. About 1 in 6 children in the state are covered by Medicaid. In addition, the Colorado Child Health Plan Plus program covers about one in every 15 children in the state.

Community health centers (CHCs) are an important source of care for low-income residents, both Medicaid-eligible, Child Health Plan Plus-eligible, and those who are uninsured or underinsured. However, CHCs are not available in all communities that have populations in need and lack sufficient capacity to meet the need in many communities where they do exist.

Many children or adolescents need some form of mental health care or counseling, but the majority

do not receive help. Not only is access to care not assured, services are not available in many areas of the state.

Additionally, oral health access continues to be a challenge, especially for uninsured or children enrolled in Medicaid. Hispanic children, compared to White, non-Hispanic children, had a significantly higher proportion of existing dental caries and untreated decay. Less than one in six Hispanic third graders had dental sealants, half the level of White non-Hispanic children. About 75 percent of Coloradans on public water systems have access to fluoridated water, but well over half a million state residents do not drink fluoridated water. A full report, The Impact of Oral Disease on the Health of Coloradans, can be found at www.cdphe.state.co.us/pp/oralhealth/Impact.pdf.

Title V has in place systems to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the state. State and local-level MCH staff are involved in priority setting and planning to meet these needs. The system is described in detail in Section II.

B. AGENCY CAPACITY

The MCH Section works with other state health department divisions and programs to promote and protect the health of all mothers and children, including children with special health care needs . The State Overview, Section III A, describes the characteristics of Colorado's population and lays out some of the challenges currently facing the state. This section provides information on the state health department's capacity to carry out its mission. The following section, organized under four headings, describes the Health Care Program for Children with Special Needs (HCP).

HCP is contained within the Children and Youth with Special Health Care Needs Section, which was created in late 2003. (See III B attachment for organizational chart). Other components of the section are Genetics and Newborn Screening, the Medical Home Initiative, the Data Integration Program, and the Newborn Hearing Program. Activities within HCP that support local and state efforts are described below. The text also describes other programs that make up the infrastructure for HCP to carry out the six MCH national performance measures directed at children and youth with special health care needs.

1. State Program Collaboration with Other State Agencies and Private Organizations for Children with Special Health Care Needs

The Health Care Program for Children with Special Needs works closely with Part C Early Childhood Connections at the Colorado Department of Education to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs. (The care coordination standards are also provided in the III B attachment). As a part of the collaboration, Part C staff are changing policies and procedures for serving infants in neonatal intensive care units. The HCP Program will be included in the initial referral process to help decide family medical and health needs and to determine the role of HCP in meeting those needs.

HCP is also beginning to use the care coordination standards in work with the Medicaid EPSDT Outreach program, thus helping to maximize EPSDT oureach services. The care coordination standards are also used with children receiving clinic services, the Colorado Responds to Children with Special Needs birth defects registry, and in the infant hearing screening followup.

The Medical Home Initiative, which began in 2000, is another example of state collaboration. The initiative is led by the Children and Youth with Special Needs Section and is designed to address the medical home national performance measure. The initiative consists of a state strategic planning group and the Medical Home Advisory Board. The Board includes staff from the state advocacy group, the University of Colorado Health Sciences Center, the Colorado Department of Education, mental health providers, health care financing experts, and pediatricians.

HCP works with JFK Partners, which is the Leadership Enhancement in Neurological Disabilities

(LEND) grantee at the Health Sciences Center, to ensure that higher education and research are supporting Title V goals.

Public health genetics services, administered or supported by governmental agencies, require a unique kind of "buy-in" and support from nongovernmental and private sector partners. The sanction of activities in public health genetics is necessary because the public is fearful of a potential loss of privacy regarding health matters, and is wary of the potential for broad discrimination based on the misuse of genetic information. These issues are further exacerbated by a questioning of the government's role in this arena. To address these challenges, HCP calls on a diverse group of medical and public health professionals, scientists, policymakers, and consumers from all major organizations in Colorado that are involved in work in genetics. The Colorado State Genetics Advisory Committee meets bimonthly to provide expert advice, review, and consultation to the state Genetics Program. The committee also ensures communication, coordination, and collaboration among the individuals and programs whose work in genetics may affect the public's health and right to privacy.

The HCP state family consultant works with a number of state agencies to establish relationships, develop memorandums of understanding, and to be available for technical assistance and followup. Local implementation of the memorandums are facilitated by HCP's regional family coordinators who are members of HCP's multidisciplinary teams in all 14 regional offices.

2. State Support for Communities for Children with Special Health Care Needs

The Health Care Program for Children with Special Needs program structure consists of a state office that supports all 64 counties in Colorado. Fourteen organized health departments serve as HCP regional offices for the other three smaller health departments and for the 39 county nursing services. All of these counties receive direct financial support through contracts with the state HCP office. With state office technical support, the 14 HCP regional offices provide administration and technical assistance to the small health departments and nursing agencies. This structure creates a strong network with personnel in every county of the state who are dedicated to serving children and youth with special health care needs. A map showing the regions is contained in the III B attachment.

Each regional office has a multi-disciplinary team of coordinators. Teams are made up of team leaders, parent/family coordinators, nurses, social workers, audiologists, speech pathologists, occupational therapists, physical therapists, vision coordinators, and nutritionists. The team provides support to the regional office, particularly in the areas of care coordination and infrastructure-building. The nurse care coordinator may delegate care coordination activities to another discipline, or seek consultation from another discipline to expedite the coordination of services. See the attachment for a description of the regional coordinator's scope of work.

Discipline coordinators have natural connections in communities that allow for the development of improved processes across agencies, as well as the ability to convene appropriate groups to address community needs. Each discipline coordinator on the team receives technical support through the state level same discipline consultant who is a state and sometimes a national leader in his field of study.

The state office also provides assistance with assessment, planning and evaluation for the regional offices. An electronic tool has been developed for local offices to help them with the planning process. Called HERMAN, HCP End of the Year Report and MCH Plan, this tool assures that attention is paid to the six national performance measures for children and youth with special health care needs. HCP also provides a state comparison of county/regional data to assist the regional offices in their planning efforts. Jefferson County's report is provided as an example at the end of the III B attachment. Finally, HCP has surveyed the regional offices to determine topics to pursue in the future through the learning community format.

3. Coordination with Health Components of Community-Based Systems for Children with Special Health Care Needs

Public health nurses and HCP's regional multidisciplinary teams work to assure that there is coordination at the local level among the services needed by families and children. Since HCP no longer provides direct care, local resources have shifted to providing care coordination services, population-based services, and to building public health infrastructure. All local HCP agencies provide resource and referral information regarding children and youth health services to the entire population. Each HCP agency provides care coordination services to targeted populations depending on community need, capacity, and reimbursement.

The Children and Youth with Special Health Care Needs Section employs a developmental pediatrician through the University of Colorado Health Sciences Center. The pediatrician works with the HCP Program and the University, training medical residents and providing public education to agencies, organizations and health care providers regarding diagnoses, the system of services, and HCP's public health role.

In the western part of the state, the Western Slope HCP regional office provides Level II and Level III care coordination in the community, assisted by state HCP office support. This work is reimbursed by the Rocky Mountain Health Plan.

HCP provides consultation to community and regional teams for children with nutrition, feeding, and growth concerns. As a result, one Diagnostic and Evaluation Clinic has added a "feeding focus" with nutrition feeding assessments and diagnoses as part of the team's activities. This service is a collaborative effort with The Children's Hospital in Denver, local hospitals, the state health department, Early Intervention Services, the child's primary care provider, the regional developmental pediatrician, community therapists, and registered dietitians. Adding a feeding focus to additional Diagnostic and Evaluation Clinics is being evaluated.

HCP provides strong support to a statewide clinic system that is a coordination of local and state resources. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

4. Coordination of Health Services with Other Services at the Community Level for Children with Special Health Care Needs

Since July 2004, the Colorado Department of Human Services has contracted with the HCP Program to provide care coordination through local offices to families of children with traumatic brain injury. The HCP Program was selected because it is the sole statewide entity with the children's services system in Colorado that can effectively connect health services with other services. Funding for this service is provided through a Traumatic Brain Injury Trust Fund created in 2002 supported by alcohol and speeding citations and fines.

Local HCP staff work closely with Part C coordinators to assure that health-related early intervention services are coordinated. Most local HCP staff are also involved in other interagency work such as serving on child protection teams, working with school districts to support parents in special education staffing, and developing Individual Education Plans or Individual Family Service Plans. HCP provides strong support to a statewide clinic system that is a coordination of local and state resources. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

State Statutes Relevant to Title V Programs

Colorado does not have a statute specific to maternal and child health. However, the Colorado Revised Statutes (CRS) 1973 states that regional health departments "shall include to the greatest extent possible, but not be limited to: (a) Personal health services, including: Communicable disease control; . . . maternal and child health services...."

The department has always carried out its MCH activities under Titles 25 and 31, the general statutory authority for the department's operation. In 1983, authority to operate a program for children with special health care needs was granted under Title 25. The Newborn Screening and Genetic Counseling and Education Act was added in 1981. This act established the department's obligation to administer programs for newborn screening, and specifically mandated testing for phenylketonuria, hypothyroidism, abnormal hemoglobins, galactosemia, homocystinuria, and maple syrup urine disease, cystic fibrosis (1987), and biotinidase deficiency (1988). After that date the legislation was revised to allow the State Board of Health to update the list of mandated tests without further legislation. In 1997, legislation was enacted concerning newborn hearing screening at Colorado hospitals. In 2001, legislation was passed concerning an immunization registry for the state.

In 2000, the General Assembly decreed that tobacco settlement agreement monies be used to develop tobacco use prevention, education, and cessation programs, related health programs, and literacy programs, and that such programs must involve cost-effective programs at the state and local levels. Funds are provided to the Children's Basic Health Plan; Comprehensive Primary and Preventive Care Grant Program (for services to low-income, uninsured residents); Nurse Home Visitor Program; Dental Loan Repayment Program; and the State Tobacco Education and Prevention Partnership.

Also in 2000, legislation was passed to create a Division of Prevention, Intervention and Treatment for Children and Youth (later renamed the Preventive Services Division) at the state health department. The legislation moved a number of programs affecting children and youth from other state agencies to the department. The legislation also required coordination across the state agencies. MCH is part of this division, as is the Children's Trust Fund, which was created in statute in 1980 to reduce child abuse and neglect.

The 2002 legislature expanded coverage through the Child Health Plan Plus for pregnant women with incomes up to 185 percent of the poverty level. In 2002, legislation was passed to create a Colorado Traumatic Brain Injury (TBI) Trust Fund and a TBI Board within the Department of Human Services. The legislature passed a child booster seat law effective in 2003. In 2003 in response to budget shortfalls, an enrollment cap was temporarily placed on the Child Health Plan Plus program for children and pregnant women. In June 2004, the enrollment cap was removed from the program.

The right of a woman to breastfeed in public was affirmed in April 2004. In July 2004, an Interagency Agreement between CDPHE and the Colorado Department of Human Services was implemented to provide Traumatic Brain Injury Trust Fund dollars for Title V care coordination services for children with traumatic brain injuries.

Medicaid presumptive eligibility for pregnant women was terminated in September 2004. However, the 2005 Legislature passed HB 1025 to restore the provision and Governor Owens signed the bill in April 2005. Presumptive eligibility is planned to be resumed in July 2005.

In November 2004, Coloradans approved a cigarette tax increase of 64 cents per pack, which is expected to generate about $175 million per year in new revenue. At the close of the 2005 session, the legislature directed that the funds be used to expand Child Health Plan Plus on July 1, 2005 by increasing the eligibility from 185% of the federal poverty level to 200%; remove barriers to care including the Medicaid assets test; eliminate the Medicaid waiting list of more than 600 special needs children for the Children's Home and Community Based Services program; support community and school-based centers that serve the uninsured and the medically indigent; provide funding for prevention, detection and treatment services for heart and lung diseases and cancer -- including the

breast and cervical cancer program; and reduce tobacco use -- especially among youth -- by fully funding the state's tobacco education, prevention and cessation programs.

In May 2005, legislation limiting the number of teen passengers allowed in a car driven by a new teen driver was passed. This strengthened the 2004 graduated drivers licensing law that increased the age for driver license permits, unless the teen was enrolled in an approved drivers training course. The new legislation also extended the length of time a teen must have a learner's permit from six months to one year, and prohibited cell phone use while driving. The new provisions will all be in effect by August 10, 2005.

State Title V Capacity to Provide a Variety of Services

A description of programs receiving some MCH funds that influence Title V's capacity to provide various services is provided below:

1. Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Women's Health Section provides a small amount of funding for direct clinical prenatal care in communities where uninsured women would otherwise not be served. The Section's activities are primarily directed toward enabling- and population-based services for women, and are offered through organized health departments, community health centers, and local nursing services. Services include smoking cessation and nutrition counseling provided through the Medicaid-funded Prenatal Plus Program. Funding will cease for direct prenatal care beginning in FY 2006, due to reduced funding levels and the focus on more population-based services.

The Nurse Family Partnership Program provides intensive nurse home visitation to first-time low-income mothers during the prenatal period up to the child's second birthday. The Prenatal Plus Program provides case management services for high-risk Medicaid-eligible pregnant women. It is a Medicaid-funded program that provides case management, nutrition, and psychosocial services to pregnant women who are assessed to be at high risk for delivering low birth weight infants.

In 2000 the Women's Health Section released a report that showed that one of the contributing factors to the high rate of low birth weight infants in Colorado was inadequate weight gain among 25 percent of pregnant women. The report led to the initiation of a statewide campaign to promote adequate weight gain during pregnancy. The campaign uses social marketing techniques, targeted materials, training, and an informational website to reach out to prenatal care providers and consumers.

2. Preventive and Primary Care Services for Children

The Child, Adolescent, and School Health Section works to protect and promote the health and well-being of all Colorado children and adolescents. Programs address health for children and youth, in communities, schools, school-based health centers, and in child care homes and centers. The Section administers programs described in this narrative such as the Nurse-Family Partnership Program, the Colorado Children's Trust Fund, and the Family Resource Centers.

The Advisory Council on Adolescent Health includes representatives from multiple state agencies such as the Department of Education, the Department of Human Services, the Alcohol and Drug Abuse Division, the Division of Youth Corrections, local health departments, higher education, health care providers, adolescent advocates, and other health department programs.

The Child, Adolescent, and School Health Section works with the Injury and Suicide Prevention Section to address shared priorities such as motor vehicle crashes and suicide prevention. The two sections successfully collaborated to receive a CDC grant to address child and adolescent violence prevention.

The Colorado Children's Trust Fund promotes prevention and education programs designed to lessen the occurrence of child abuse and neglect and to reduce the need for state intervention in child abuse and neglect. The program focuses on parent education for both the at-large population and those identified as at-risk to perpetrate abuse. The Trust Fund currently provides training and funding for communities interested in implementing the Nurturing Parenting Program, an evidenced-based program shown to increase parenting skills and decrease the risk of child abuse.

The Family Resource Center program provides oversight and coordination of federal funding available to support family resource centers across the state. Training, technical assistance and support is provided through a contract with the Family Resource Center Association to 24 family resource centers.

The School-Based Health Centers Program and the Colorado Association for School-Based Health Care convene, facilitate, and provide technical assistance to schools and provider agencies that develop, implement, and support school-based health centers.

The Suicide Prevention program focuses on building local capacity to be more effective in suicide prevention for all ages. Work is done through coordination with communities, the Suicide Prevention Coalition of Colorado, numerous agencies, mental health professionals, and suicide survivors.

The Youth Partnership for Health is composed of 25 teens recruited from all areas of Colorado. The partnership advises the state health department on policies and programs that affect adolescents.

3. Services for Children with Special Health Care Needs

The Health Care Program for Children with Special Health Care (HCP), within the Children and Youth with Special Health Care Needs Section of the Colorado Department of Public Health and Environment, is responsible for building family-driven, sustainable systems of health services and supports for children and youth with special needs. Through interagency collaboration, the program connects families to culturally respectful, community-based resources. There are now 14 county-level offices statewide that assist families in obtaining needed care and services.

The Colorado Medical Home Initiative promotes a team-based approach to providing health care. Children and youth with special health care needs may have many professionals invested in their physical and emotional well-being. Coordination of care is an essential activity to assure communication and planning among team members, including family, primary health care practitioners, specialists, community programs, and insurance plans.

Colorado Responds to Children with Special Needs (CRCSN) is Colorado's birth defects monitoring and prevention program. CRCSN maintains a database with information about young children with birth defects, developmental disabilities, and risks for developmental delay. The program provides data to other programs, agencies, and researchers. CRCSN and HCP share data so that HCP can link children and families, who have been identified with birth defects and related disabilities, with early intervention services through the HCP CRSCN Notification program.

The Diagnostic and Evaluation (D&E) Program, also called the Diagnostic and Evaluation Clinics, provides access to comprehensive, multidisciplinary, developmental evaluation services for children who have or are suspected of having a developmental delay or disability. The program provides the needed medical diagnosis for many children who do not have access to a developmental pediatrician. It is community-based and coordinated with the Colorado Department of Education's Child Find and other local specialty providers. To ensure that D&E clinics are part of a child's medical home, training and consultation are provided to primary care physicians.

The Colorado State Genetics Program works to protect and improve the health of all Coloradans by promoting the availability of high quality, comprehensive genetic diagnostic, counseling, screening,

treatment, and referral services.

The Newborn Screening Program provides screening at birth and again at 8 to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. Presumptive positive screens are followed annually to make sure that affected infants are diagnosed and receive timely referral and treatment.

The Infant Hearing Program tests the hearing of infants at birth and identifies deaf and hearing-impaired infants and makes appropriate referrals. To support the program, a Colorado Infant Hearing Advisory Committee was formed, comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies. The advisory committee is very active, meeting quarterly, and supporting a variety of specific task forces that address issues and develop additional guidelines.

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. Staff of the Health Care Program for Children with Special Needs in the local health departments become involved when families have more complex medical or psychosocial needs needing care coordination.

In another effort, a durable medical equipment loaner bank is being developed. The state HCP occupational therapy/physical therapy consultant is building a statewide coordinated network to facilitate the development and expansion of a voluntary bank. Occupational and physical therapy coordinators have surveyed their regions for both the existence of and the need for loaner systems. A statewide Web site is planned for FY 2006 that will list inventory and conditions for accessing inventory. Parents and professionals will be able to list and locate inventory for use by a child or family.

The durable medical equipment loaner bank will be completely voluntary for all parties; none will incur responsibility as to the condition or fitting of equipment. Regional coordinators will be available to assist facilities or programs with the Web site and with initial inventory identification and entry. HCP staff plan to use volunteers, including high school and college students, in the effort to identify and inventory equipment. Satisfaction surveys will be used to measure the success of the system.

Family-centered, community-based, coordinated care including care coordination is another responsibility of the HCP program, which is engaged in a public education campaign to assure that all families of children with special health care needs know about the services that are available to them. This campaign also targets health care providers and partner agencies.

4. Culturally Competent Care that is Appropriate to the State's MCH Population

In 2005, the Office of Health Disparities was established within the department, taking the place of the Turning Point Initiative. A Citizen's Commission on Minority Health was also initiated to coordinate the department's efforts in working with underserved communities.

MCH embraces the value of providing culturally competent care. Programs work to offer services that are culturally appropriate and ensure that materials are available in Spanish as well as English. Many care providers and other staff at the local level are bilingual (Spanish and English) and familiar with the cultural beliefs and health practices of the populations they serve. Outside of major urban areas it can be challenging to provide linguistic and culturally appropriate care for people from other (non-Anglo or non-Latino) groups.

Other Programs Supported by MCH funds

Child and maternal mortality reviews are done by a multi-disciplinary team working together to determine the underlying causes of maternal and child deaths. The reviews also promote preventive programs that may help reduce premature death. Multiple agencies and department programs are involved in both reviews.

The Family Healthline is the statewide MCH information and referral service. The Healthline resource specialist assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialist speaks fluent Spanish and English. Special arrangements are made for assisting the hearing-impaired and speakers of other languages.

The Oral Health Program works to improve the oral health status of Colorado residents by reducing dental diseases through preventive measures and by reducing barriers to accessing oral health care. This is done primarily through water fluoridation, elementary school fluoride mouth rinses, dental sealants, and oral health education. A state oral health surveillance system is being developed. Staff seek to integrate oral health into general health within programs within the state health department. A statewide oral health improvement plan is also being developed.

The State Systems Development Initiative works to build capacity to access and use data in MCH planning. MCH county data sets, which provide a wealth of information about MCH populations, are updated annually and distributed to local public health agencies. Trend analyses and a table of each county's rates for the MCH Performance and Outcome Measures are also available. The information is at www.cdphe.state.co.us/ps/mch/mchdatasets.html.

C. ORGANIZATIONAL STRUCTURE

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all located in Denver. Douglas Benevento, JD is the Executive Director, and reports to Governor Bill Owens. A CDPHE organization chart is posted at http://10.1.0.61/ic/orgchart.pdf.

CDPHE consists of ten divisions. The Prevention Services Division is responsible for administering the MCH Block Grant, and the Division Director is Jillian Jacobellis, PhD. The Division administers eight sections: Nutrition Services; Chronic Disease; State Tobacco Education and Prevention Partnership; Oral, Rural and Primary Care; Women's Health; Child, Adolescent, and School Health; Children and Youth with Special Health Care Needs; and Injury and Suicide Prevention. The division houses a wealth of talent and resources relevant to women's and children's health, as well as expertise in health promotion and disease prevention. A division organization chart is attached to Section III D.

D. OTHER MCH CAPACITY

Title V funds and matching state funds pay for 47.7 FTE almost exclusively housed at the Colorado Department of Public Health and Environment in Denver.

The Office of Maternal and Child Health is directed by Joan Eden, RD, MS, and is composed of four units. A fiscal and contracts management section is led by Sally Merrow. The SSDI Coordinator, Jan Reimer, works with the MCH Epidemiologist, Bill Letson, MD, and a statistical analyst. Geoff Bock manages the MCH Data Services unit. Sue Ricketts, PhD is the MCH Demographer and is assisted by a statistical analyst.

Senior staff associated with MCH-priority area sections are Karen Trierweiler CNM, MS, Director of the Women's Health Section, Barbara Ritchen, RN, MS, Director of the Child, Adolescent, and School

Health Section; and Kathy Watters, MA, Director of the Children and Youth with Special Health Care Needs Section. Organizational charts for the Office of Maternal and Child Health and the Prevention Services Division are attached.

There is one paid FTE family consultant within the Health Care Program for Children with Special Health Care Needs at the state health department in Denver. Each of the regional offices associated with the program has a family consultant.

Brief Biographical Information for Key MCH Management Staff

Joan Eden, RD, MS
Director of the Office of Maternal and Child Health and
Deputy Director of the Prevention Services Division

Joan Eden has a Master of Science Degree in Public Health and Nutrition from Columbia University. She is also a Registered Dietitian. Before coming to Colorado, she worked in New York City in a Maternal Infant Care Project as a clinical nutritionist. She has been with the state health department for 27 years working with the Migrant Health Program, the Prenatal Program, and the Child Health Program as a Nutrition Consultant. She served as the state's Children with Special Health Care Needs Director for eight years before becoming the state's Maternal and Child Health Director in October of 2000. She also serves as the Deputy Director of the Prevention Services Division.

Bill Letson MD, MS FAAP
Pediatric Consultant/Maternal Child Health Epidemiologist

Dr. Letson is trained in Pediatrics, Infectious Diseases and Public Health Epidemiology. He is from a Colorado Western Slope pioneer family and received his medical education at the University of Colorado. Dr. Letson's Pediatric and Chief Residency was completed at the University of Arizona. He completed a Pediatric Infectious Diseases fellowship at Johns Hopkins University, and additional Public Health Training at the Centers for Disease Control and Prevention, including a fellowship in Maternal Child Health Epidemiology. In addition to working for eight years on vaccine studies with CDC at Indian Health Service sites, Dr. Letson has practiced community pediatrics at clinics for uninsured children. He was also MCH director and Chief Medical Officer for the state of Wyoming.

Jan Reimer, BA
Coordinator, MCH State Systems Development Initiative (SSDI)

Jan Reimer has been the MCH State Systems Development Initiative Coordinator since 1993. Prior to this position she was the Coordinator of the Refugee Health Care Access Program for the State Health Department. Ms. Reimer was educated at Macalester College in St. Paul, Minnesota and holds a Bachelors of Arts in Sociology.

Sue Ricketts, M.A., PhD
Maternal and Child Health Demographer

Dr. Ricketts has been at the Colorado Department of Public Health and Environment for more than 20 years. She has long been involved in public health research in maternal and child health, particularly issues related to teen fertility, prenatal care, and low birth weight. Dr. Ricketts began her career at the Population Council in New York City, and came to Colorado to work at the former U.S. Department of Health, Education, and Welfare. She has also worked at the national Education Commission of the States in Denver and taught at Colorado Women's College and the University of Colorado at Denver. She holds an undergraduate degree in Economics from Wellesley College, and an M.A. and Ph.D. in

Demography from the University of Pennsylvania.

Barbara Ritchen, RN, MA
Director, Child, Adolescent and School Health Section

Barbara Ritchen has been with the Colorado Department of Public Health and Environment since 1985, first as Director of the Adolescent Health Program, then of the Child, Adolescent and School Health Section. During that time she also directed a national center, funded by the federal Maternal and Child Health Bureau, to promote adolescent health leadership and to provide training and technical assistance to state MCH programs across the country. Her areas of expertise include child, adolescent and school health; training; team development; facilitation; leadership; health education and health promotion; community development; needs assessment and strategic planning. Barbara's background includes a Bachelor of Science in Nursing from the University of Texas and a Master's Degree in Health Education from the University of Northern Colorado.

Karen Trierweiler, CNM, MS
Director Women's Health Section

Karen Trierweiler is a certified nurse midwife with over 25 years of experience in women's health as a clinician, educator, and public health professional. She received both her undergraduate and Master's degrees in Nursing from the University of Colorado. Ms. Trierweiler has worked at the Colorado Department of Public Health and Environment since 1990, originally as a nurse consultant, and since 2000, as the Director of the Women's Health Section.

Kathy Watters, MA
Director Children and Youth with Special Health Care Needs Section

Kathy Watters came to the Colorado Department of Public Health in 1984 from the Colorado Department of Education's State School for the Deaf and Blind. She received her undergraduate degree in Communication Disorders from the University of Cincinnati and her Master's degree in Audiology from the University of Colorado-Boulder. Kathy began her career at the state health department as the Home Intervention Program Director. She subsequently became the Hearing and Speech Director, the Consultation Team Director, the HCP Assistant Director, and the HCP Director. She is now the Section Director for Children and Youth with Special Health Care Needs.

MCH funds are distributed to local contractors (primarily health departments and nursing services) via a formal planning process. Baed on the state-defined MCH priorities, contractors are asked to assess and prioritize the local health status needs of the perinatal, child and adolescent, and children with special health care needs populations; and to identify how their allocated MCH funds will be used. The services or activities they implement are expected to address the ten Colorado MCH priority areas.

The state-level MCH program assists agencies by providing consultation and technical assistance in developing and carrying out plans. Also, state-prepared model plans associated with priority areas are available. The plans consist of already developed goals, objectives, activities, process evaluation methods and outcome evaluation methods. Agencies can choose to implement one of these model plans or they may develop their own workplan. More information about the MCH planning process and forms are at www.cdphe.state.co.us/ps/mch/plan/forms.html.

E. STATE AGENCY COORDINATION

Relationships among the State Human Service Agencies

MCH staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees, and cooperative agreements. The following text briefly describes a few key relationships.

An Interagency Prevention Council has existed for many years, and in 2000 was mandated through statute. The Council has created a more unified, effective and efficient approach to the delivery of state and federally-funded prevention, intervention and treatment services for children and youth in Colorado. More information can be found at www.cdphe.state.co.us/ps/ipsp.

The Colorado Department of Education is a close partner of the Title V program in supporting the coordinated school health model, school nurses across the state, and school-based health center activities. MCH has partnered with the Department of Education to support school health education, statewide conferences, adolescent health training, the Youth Risk Behavior Survey, and the Adolescent Health in Colorado Report.

The Colorado Department of Health Care Policy and Financing houses the Medicaid and children's health insurance plan for the state. The agencies work together to improve the health of Medicaid-eligible women and children and on issues such as EPSDT, lead poisoning, family planning, immunizations, birth defects, Prenatal Plus, and oral health.

The Colorado Department of Human Services (in particular the Division of Developmental Disabilities) is a close partner of Title V. There are ongoing interactions in the provision of services for the many children served by the Health Care Program for Children with Special Needs, children who are also eligible for services through the Colorado Department of Human Services. Programs include Early Intervention Services for child development for infants and toddlers birth to age three; Family Support Services Program for families who maintain a family member with developmental disabilities in the family home (all ages); Children's Extensive Support Waiver for children birth to 18 who are considered to be the most at-risk for out-of-home placement due to the severity of their needs; and the Children's Medical Waiver for children age birth to 18 with developmental disabilities that allows access to Medicaid state plan benefits for children who would otherwise be ineligible due to parental income. The state health department works closely with the Alcohol and Drug Abuse Division to plan coordinated workforce development and joint training and technical assistance. Other partners include the Division of Youth Corrections, the Mental Health Division, the Child Care Division, and the Child Protective Services Division.

Relationships with Federally Qualified Health Centers and Primary Care

The Colorado Community Health Network (CCHN) is the state primary care association representing 15 community, migrant, school-based, public housing, and homeless centers operating 108 health care delivery sites. Colorado's community health centers provide over 1.5 million visits to over 392,000 low-income patients each year, many of them women and children. Community health centers are the medical home for an estimated 28 percent of Colorado's low-income, uninsured population, 34 percent of Child Health Plan Plus enrollees, and 28 percent of Medicaid enrollees.

The Rural and Primary Care Office within the Oral, Rural and Primary Care Section works with CCHN to improve accessibility and expand primary care services to targeted low-income and vulnerable populations. These efforts include information and data sharing; recruitment and retention of health professionals; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

Relationships with Local Public Health Agencies

The MCH program works through the state health department's Office of Local Liaison to address MCH issues in the 39 counties with local nursing agencies. The MCH program works directly with the 15 organized health departments that serve the 25 largest counties in the state. MCH funds are distributed to local health agencies to assess the MCH population needs in their communities and to address priorities.

Relationships with Tertiary Care Facilities

MCH has a good working relationship with Denver Health, the largest community health system in the country. Denver Health includes Denver Health Medical Center, community health centers, school-based health centers, and the public health department for the city and county of Denver. The MCH program also works closely with The Children's Hospital, the state's only hospital for children. The Health Care Program for Children with Special Needs funds a position at the hospital to coordinate the inpatient and outpatient services provided through the hospital with those services needed and provided in the community.

Available Technical Resources

The Department of Preventive Medicine at the University of Colorado at Denver and Health Sciences Center provide technical resources to MCH programs. JFK Partners, a joint program between the Departments of Pediatrics and Psychiatry, is also another valuable resource. JFK Partners is the Leadership Enhancement in Neurological Disabilities grantee and focuses on children with developmental disabilities and special health care needs. The University of Colorado at Denver and Health Sciences Center School of Nursing and the Center for Human Investment Policy at the University of Denver also provide technical assistance on conducting community needs assessments; and provide legislative, policy, and research updates.

The Colorado Regional Institute for Health and Environmental Leadership housed at the University of Denver provides an Advanced Leadership Training Program for public health staff.

Colorado actively participates with other Title V directors and staff in planning initiatives associated with the MCHB-funded Rocky Mountain Public Health Education Consortium. Title V also encourages the participation of state and local-level MCH staff in the Rocky Mountain Public Health Education Consortium products such as the Summer Institute in Maternal and Child Health in Salt Lake City, the MCH Certificate program, and available distance learning courses.

Title V Program Coordination with other Specific Programs

The MCH Program works with many other programs within and external to the state health department. The following list is incomplete, but includes some programs not funded by Colorado Title V or other federal programs.

The Aurora Healthy Start Initiative is located in the city of Aurora, adjacent to Denver. The program developed in response to exceptionally high infant mortality in two zip code areas. MCH assists by providing demographic and health risk information for the two zip code areas, and by sharing materials and resources.

The Colorado Breastfeeding Task Force is a volunteer organization that works to ensure optimal health and development of mother infant bonding by increasing Colorado breastfeeding rates, particularly among underserved populations.

The Colorado Perinatal Care Council is a statewide organization of perinatal care providers. The Council's major focus is the coordination and improvement of perinatal care services in Colorado. The

state health department provides space and support for the Council, which is co-located with the MCH program. The Council is a volunteer, non-profit, advisory group whose members include obstetricians, pediatricians, perinatologists, social workers, neonatologists, and nurse practitioners.

Colorado Covering Kids & Families (CKF) is a coalition-based project aimed at reducing the number of uninsured children. CKF has a membership of over 200 community-based organizations, agencies, and individuals. Through outreach efforts, CKF works to ensure that all eligible children and adults are enrolled in public health insurance programs.

The Folic Acid Task Force works to design and implement programs that will increase folic acid consumption among Colorado women by means such as targeted social marketing campaigns.

Healthy Child Care Colorado's goal is to provide safe and healthy child care environments; to increase accessibility to immunizations; and to provide access to quality health, dental, and developmental screenings and follow-up by supporting a network of child care health consultants. The initiative is an educational resource for center and family child care providers throughout the state. The project was previously funded through the Maternal and Child Health Bureau as part of the Healthy Child Care America initiative. When the funding ended in January 2005, the Child, Adolescent and School Health Section agreed to continue supporting the project through the MCH Block Grant.

Oral Health Awareness Colorado (OHAC!) is the statewide oral health coalition. The coalition has two primary goals: to maintain a media campaign ("Be a Smart Mouth"), and to develop a state oral health plan. The coalition is in the process of developing a statewide oral health improvement plan. The web address is www.beasmartmouth.com.

The State Tobacco Education and Prevention Partnership is funded from the state tobacco master settlement agreement monies. Goals include decreasing youth tobacco initiation; promoting quitting of tobacco among youth and adults; and reducing exposure to environmental tobacco smoke.

The Tony Grampsas Youth Services is a statutory program housed in the Child and Adolescent School Health Section. It provides funding to local organizations that target youth and their families with programs designed to reduce youth crime and violence. The program also focuses on funding programs that prevent or reduce child abuse and neglect.

Title V Program Coordination with Other Specific Programs

1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

In 2003 after over 20 years of being responsible for case management and outreach portions of the Colorado EPSDT program, the state health department ceased administration of the program. The Medicaid Program now contracts directly with local health agencies. However, Health Care Program for Children with Special Needs local and regional care coordinators work with EPSDT staff on a daily basis. In almost every county health agency, the EPSDT coordinators work with other public health service programs such as WIC, prenatal, child health programs, immunization services, and the Health Care Program for Children with Special Needs. At the state level, Title V continues to work with EPSDT and to participate in the EPSDT State Advisory Board. EPSDT staff also serve on the Health Care Program for Children with Special Needs Medical Home Advisory Committee.

2. Other Federal Grant Programs

The WIC Program resides in the same division as the Office of Maternal and Child Health. Joint efforts for improving certain MCH performance measures have been in place for years. Current efforts are focused on increasing immunization and breastfeeding rates and decreasing childhood overweight. WIC funds go to all of the local health agencies.

Colorado is one of nineteen states that have received a CDC Coordinated School Health Program grant. The project's purpose is to build partnerships and an integrated, sustainable system that directly supports the missions of both the Colorado Department of Education and the Colorado Department of Public Health and Environment. Expected results are improved academic and health outcomes for Colorado school-aged children and youth.

An Early Childhood Comprehensive Systems Building grant is funded by the Maternal and Child Health Bureau. The initiative began in 2003 with a focus on creating a strategic plan to support a comprehensive early childhood system, which includes health, mental health, early care and education, family support and parent education. There are currently eight task forces working on the goal areas of Colorado's strategic plan: Program Quality and Standards, Program Availability, Finance, Organizational Structure, Policy, Public Engagement, Parent and Family Engagement and Outcome and Evaluation. The two-year strategic planning grant ended June 30, 2005 and implementation funding through the Maternal and Child Health Bureau is anticipated in the fall of 2005.

Title X Family Planning is housed within the Women's Health Section, which also administers the prenatal component of the MCH Block Grant. The MCH Block grant and Title X family planning activities are well-integrated. Activities to address unintended pregnancy and teen fertility are targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning services, but rather to support population-based activities around family planning and unintended pregnancy prevention.

The Child and Adult Care Food Program is a USDA funded program that provides reimbursement for nutritious meals and snacks served to eligible children in child care centers, family day care homes, and eligible adults in adult care centers. Work has been coordinated regarding healthy child care initiatives.

The Colorado Physical Activity and Nutrition Program (COPAN) is funded by CDC. The program developed and is implementing the Colorado Physical Activity and Nutrition State Plan 2010. The plan promotes healthy eating and physical activity to successfully prevent and reduce overweight, obesity, and related chronic diseases. MCH staff serve on the early childhood and school site task forces, planning joint videoconferences and tool kits.

Early Hearing Detection and Intervention (EHDI) is funded by a CDC grant. The grant allows for the integration of a variety of databases beginning with the universal newborn metabolic screening and infant hearing screening data. It will include the Birth Defects Monitoring Program, an immunization registry, and asthma surveillance data. Clinical databases have been created for Sickle Cell Disease, the Inherited Metabolic Diseases, and infant hearing loss. Work has begun on the central processing database and its linkage to the recently created databases and the Integrated Registration and Information System (IRIS). Also underway is the implementation of the CHIRP/NEST (Clinical Health Information Record of Patients/ Newborn Evaluation Screening and Tracking) applications.

Violence reduction efforts are funded by CDC. Colorado is one of eight states to receive CDC funding for a two-year program that will work to support change in societal norms and environmental conditions contributing to violence. A strategic plan is being developed that addresses shared risk and protective factors for violence among children and youth.

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for other services.

The majority of local MCH contractors also served as presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program (authorized under Colorado's Medicaid state plan) allowed Medicaid presumptive eligibility determinations to be made at public health sites. MCH contractors identified

women and infants who were eligible for Medicaid at the local public health site (through WIC, family planning, EPSDT, etc.), and deemed them presumptively eligible for Medicaid if the income requirements were met. With the elimination of the presumptive eligibility program, local sites are now assisting clients in completing Medicaid applications and working with both state and local social service providers to expedite eligibility determinations. Women are then referred to community resources for direct care, case management, and other services. Eligibility determinations are also made for Child Health Plan Plus in many of these same sites. Presumptive eligibility determination is expected to be reinstated in the coming year.

4. Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and Family Leadership and Support Programs

Social Security Administration (SSA)

Relationships with the State Determination Unit of the Social Security Administration are strong. Local level EPSDT outreach workers make calls to families of children receiving SSI to assess whether service and support needs are being met. Referrals are made to the Health Care Program for Children with Special Needs when family needs are complex and the EPSDT outreach worker feels that care coordination by a Health Care Program for Children with Special Needs staff member is appropriate.

Developmental Disabilities

This area was addressed in the Colorado Department of Human Services section under Relationships among the State Human Services Agencies.

Vocational Rehabilitation

Relationships with Vocational Rehabilitation have been cultivated through the Colorado Interagency Transition Team. This team of ten stakeholders collaboratively addresses the topic of youth transition to adulthood for the state of Colorado. In 2005, the state health department was invited to participate on the team with HCP as the representative. Also, a representative from Vocational Rehabilitation sits on the Colorado Health Transition Coalition, initiated and led by HCP. Both the Department of Education's Special Education Section and Vocational Rehabilitation are actively involved in the Brain Injury Steering Committee and a task force on Assistive Technology.

Family Leadership and Support

Title V has supported Family Voices Colorado financially and through membership on its board of directors since it became an official chapter in 2001. Family Voices is involved in the Medical Home Learning Collaborative. Family Voices also works with the state-level Children and Youth with Special Health Care Needs family position and local family consultants to implement the Family-to-Family Health Information Network, and provides state level family advocacy. The Health Care Program for Children with Special Needs has also financially supported the Colorado Families for Hands & Voices to engage in family advocacy, outreach to underserved populations, and parent leadership activities in our EHDI systems grant.

A number of examples of state agency coordination have been provided in this section, but this list does not contain every cooperative effort. Other examples are provided in the text in other sections, particularly in the performance measures sections (IV C and IV D).

F. HEALTH SYSTEMS CAPACITY INDICATORS

#01 Health Systems Capacity Indicator
The rate of children hospitalized for asthma (per 10,000 children less than 5 years old)

Data provided from calendar year 2000 through calendar year 2002 show an increase in the asthma hospitalization rate from a low of 51.3 hospitalizations for every 10,000 children age 0 through 4 in calendar year 2000 to 60.8 in 2002. For calendar year 2003 (FY 2004), the rate was 63.2, the highest level in the 10 years of data available.

#02 Health Systems Capacity Indicator
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen

Data for FY 2004 showed that 84.2 percent of all Medicaid enrollees under one year of age received at least one initial periodic screen.

Data for FY 2003 showed that 88.4 percent of all Medicaid enrollees under one year of age received at least one initial periodic screen. Prior to FY 2003, the percentage had varied between 90 and 100 percent.

#03 Health Systems Capacity Indicator
The percent of Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen

The Child Health Plan Plus has not been able to provide this information in past years due to limitations in linking datasets between enrollment data and claims data. For the FY 2006 grant application, no new information is available.

#04 Health Status Indicator
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index

After declining for five years in a row (1998-2002), the percentage of women with adequate prenatal care increased nearly one percentage point in calendar year 2003 from 66.3 percent (calendar year 2002) to 67.1 percent (calendar year 2003). However, this percentage is still lower than Colorado's rate in the late 1990s. An analysis of Colorado's ranking (available from the MCH Bureau's website) shows just six other states with proportions this low in recent years.

#05 Health Systems Capacity Indicator
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

According to PRAMS data, from 1999 through 2003 the low birth weight rate ranged from 8.2 percent to 9.3 percent for Medicaid births, and 7.0 to 7.9 percent for non-Medicaid births. Data from PRAMS and the birth certificates indicate that the low birth weight rate is increasing for all women in Colorado.

Infant death rates are not available for Medicaid/non-Medicaid population comparisons. Although the linked birth and death certificate data file is available, Colorado does not collect Medicaid information on the birth or death certificate. The overall infant death rate was 6.0 per 1,000 in 2003.

The percent of pregnant women entering care in the first trimester has decreased since 1999 for both Medicaid and non-Medicaid births. According to PRAMS data, 61.4 percent of Medicaid births received prenatal care in the first trimester in 2003 compared to 69.4 percent of births in 1999. The percent for non-Medicaid births is 86.2 in 2003, a drop of 2.5 percentage points since 1999.

In 2003, the percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80 percent [Kotelchuck Index]) among Medicaid births was estimated to be 57.8 percent and 74.2 among non-Medicaid births according to PRAMS data. The Medicaid rate is significantly lower than the non-Medicaid rate. As would be expected, given the decrease in the proportion of pregnant women receiving care in the first trimester, the Kotelchuck Index has been declining since 1999.

#06 Health Systems Capacity Indicator
The percent of poverty level for eligibility in the State's Medicaid and CHIP programs for infants (0 to 1), children, and pregnant women

The percent of poverty level for eligibility in Colorado's Medicaid plan has been 133 percent for pregnant women and for infants and children less than or equal to 5. The rate drops to 100 percent for children 6 to 18. In the spring of 2005 legislation eliminating the assets test for all families with children age 1 or older was enacted. The test had limited a family to $2,500 in assets including a car valued at no more than $1,500, although the test did not apply to pregnant women or to children under 1. Beginning July 2005, the assets test was eliminated for all children and the Medicaid poverty level was expanded to include those under 150% of poverty.

The state Child Health Plan Plus percent of poverty level has been 185 percent for infants, children, and pregnant women. No assets tests was applicable for this program. Pregnant women were not included in the Child Health Plan Plus until October 2002. This expansion of the poverty level was intended to cover an additional 3,000 pregnant women annually. The program for pregnant women was suspended in April 2003, but was resumed in July 2004. A total of 480 women were served before suspension of the program; data are not available since resumption of coverage.

Also because of state budget constraints, the Child Health Plan Plus enrollment for children was capped in November 2003, and no more children were enrolled until the program reopened enrollment in July 2004. Estimates of the number of children covered in 2004 were in the 35,000 range, substantially below the number previously covered (53,000 in 2003).

Beginning July 2005, the CHP+ will include children and pregnant women below 200% of the federal poverty guideline.

#07 Health Systems Capacity Indicator
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year

Data for FY 2004 from HCFA Form 416 show that 28,287 children received dental services through Medicaid, out of a total of 54,590 children. These figures result in 51.8 percent of EPSDT eligible children receiving dental services, a slight increase from the 50.6 percent of children served in FY 2003.

The raw data reveals that an increased number of children were served in FY 2004 (28,287) compared to FY 2003 (24,067) and that the total number of children who were eligible jumped to 54,590 from 47,542. The increase in the total number of children eligible is 14.8 percent, while the increase in the number served is 17.5 percent.

With the significant increase in number of children eligible for Medicaid, it is a success that the percent receiving dental services also increased overall. The number of Medicaid providers increased by nearly 8 percent in FY 2004. The state Dental Loan Repayment Program continues to receive funding from the state tobacco settlement fund ($200,000 per year), allowing assistance to seven to eight dental providers each year, who must agree to a two-year commitment. Many more Medicaid children are being served as the program entices new Medicaid providers and assists in retaining

current ones. In FY 2004, 6,807 Medicaid children were served by loan repayment participants compared to 3,629 in FY 2003. In addition, dental practices serving Medicaid children are continuing to expand, many through the assistance of the Comprehensive Primary and Preventive Care grants program administered by the Department of Health Care Policy and Financing, which is also funded by the tobacco settlement.

#08 Health Systems Capacity Indicator
The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program

Data through FY 2003 showed that 1 in every 6 or 7 children on SSI in Colorado received rehabilitative services from the state Health Care Program for Children with Special Needs. Since July 1, 2003, however, these services are no longer covered by the program. Data for FY 2004 therefore show a zero for the percentage receiving such services.

#09(A) Health Systems Capacity Indicator
The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data

Information about the ability of the state to assure access to data is available in Form 19. The MCH program has ready access to birth and infant death certificate data and PRAMS data. The program has the ability to obtain data from the birth defects surveillance system, and from hospital discharge data, but access is not timely for the hospital discharge data set due to limited staff resources.

There is no linkage between birth records and WIC eligibility files. Linkage between birth records and Medicaid claims data is not currently available, but work is progressing toward such access. Claims data for women who receive Prenatal Plus services, the state's program for high-risk Medicaid women, is anticipated in the summer of 2005.

Linkage between birth records and newborn screening files, including hearing screening, is under development, since both programs are located at the state health department. We anticipate a linked database some time during calendar 2006.

The Colorado Health Information Dataset (CoHID) provides a great deal of information on births and deaths, injury data and population data. This website is located at www.cdphe.state.co.us/cohid. The user can choose a topic and select years, counties, and characteristics. While the dataset is not designed for large or detailed data analysis, it provides a wealth of data for users.

A new birth certificate is planned for January 2006. Medicaid status will be included on the form. This addition will greatly enhance the ability to assess the health status of birth outcomes for the Medicaid population.

#09(B) Health Systems Capacity Indicator
The percent of adolescents in grades 9 through 12 who reported using tobacco products in the past month

The Colorado Youth Risk Behavior Survey provides data on this measure every other year. The year 1995 was the last year with a large enough sample size for valid statewide estimates; subsequent surveys had too few participants. The next survey will take place in the fall of 2005.

The state health department coordinates the Youth Tobacco Survey, which was carried out in 2000 and 2003. The data from the 2000 survey provide valid statewide estimates. However, the 2003 survey did not have a large enough sample size to provide valid statewide data. Access to the

database is assured.

In addition, the department has access to the Youth Tobacco Attitudes and Behavior Survey which was carried out in 2001 and is expected to be repeated in the spring of 2006.

#09(C) Health Systems Capacity Indicator
The ability of States to determine the percent of children who are obese or overweight

The Colorado Youth Risk Behavior Survey (YRBS) provides data on this measure, but the 2003 survey, carried out in the fall of 2003, did not yield weighted data. The next YRBS will be completed in the fall of 2005. The new Child Health Survey, begun in January 2004, attempts to measure overweight (the complete format of the survey and all questions are attached to this section). Data from the new survey became available in the summer of 2005. The state WIC program also participates in the Pediatric Nutrition Surveillance System (PedNSS) and data on obesity among children under the age of 5 are available.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

B. STATE PRIORITIES

Colorado's ten state priorities are:

1) Improve healthy birth outcomes for pregnant women
2) Improve access to health care for MCH populations
3) Improve immunization rates for all children
4) Reduce the adolescent fertility rate
5) Reduce rates of child and adolescent motor vehicle injury and death
6) Improve preconceptual health among women
7) Reduce the incidence of overweight among children and teens
8) Improve the mental health of MCH populations
9) Improve the health of children
10) Reduce the use of tobacco, alcohol and other drugs among MCH populations.

A chart showing the state priorities, the national performance measures, and the state performance measures is attached to this section. "Priority Areas, National Performance Measures, and State Performance Measures Colorado FY 06" delineates the relationship between the priority areas and the two types of performance measures.

The process used to determine the state's priority needs involved assessing the needs, examining the capacity, selecting the priority needs and performance measures, and setting the targets. We began with a comprehensive analysis of current data on the health status of the maternal and child populations that was utilized by state and local stakeholders and state-level program administrators and consultants in determining what the priority needs would be. This analysis, "The Health Status of Colorado's Maternal and Child Health Population" is contained in the Section II narrative.

In the 2005 Needs Assessment process, the input of multiple stakeholders was solicited. This was expedited through the use of internet resources that have become available in recent years. We began the needs assessment process with an electronic survey designed to solicit the perception of stakeholders from around the state regarding the needs and emerging issues. Our intent was to identify any additional issues for which we needed to gather data and information.

The health status report was successful in providing needed information from the responses of over 700 individuals, identifying access to care and the lack of insurance for specific populations and types of care as issues of concern for which we needed to seek out additional data. Such data was included in the "The Health Status of Colorado's Maternal and Child Health Populations"as a result. We also used an Internet-based technology, WebIQ, for the more comprehensive Stakeholder Input process that responded to the data in the health status report. In the 2005 Needs Assessment process a series of meetings that used Internet technology connected the stakeholders in a discussion of priorties and resulted in a ranking of the priorities.

The use of the Internet-based survey tool and the WebIQ technology for the participation of MCH stakeholders facilitated the participation of a much broader spectrum of stakeholders than was possible five years ago. The amount of time that the participants needed to commit to was limited to one hour sessions with several options of available dates and times. Participants could "attend" from their own offices, and could gathering appropriate staff members together who could participate simultaneously by conference call and through their computer keyboards. The technology allowed the

participants' input to be displayed immediately, commented on, added to, voted on, and ranked using standardized criteria.

The data contained in "The Health Status of Colorado's Maternal and Child Health Population" provided the evidence upon which Colorado's priorities are based. The list of priorities for the next five years is similar to the list that was in effect for the past five years. This finding underscores the importance of addressing basic maternal and child health issues which may not be easily accomplished. Access to care, reduction of harmful behaviors, and improvement in healthy behaviors over time will lead us closer to fulfilling the goals that our priorities promise. Colorado's priorities cover a broad range of issues that are all important to the health of mothers and children in our state.

FY 2006 New Performance Measures

The following summarizes plans for addressing the new FY 2006 state performance measures resulting from the needs assessment process.

New State Performance Measure 4

The rate of birth (per 1,000) for Latinas aged 15-17

The FY 2006 target is set at 73.7 births per 1,000 teens age 15-17.

This target is the baseline level of Latina teen fertility for calendar 2003, the most current available. The primary intent of this project is to gain a fundamental understanding of the Latino/a teens, parents, and community providers' viewpoint on teen sexuality and pregnancy prevention. The Latina Teen Fertility Project has two phases (I and II) and the final report will provide baseline information for this measure.

The first phase of the Latina Teen Fertility Project began in August 2004 and continued through FY 2005. A contractor was hired to develop an exploratory study to explore the various sociocultural factors related to Hispanic/Latina teen pregnancy in Colorado. The contractor organized and facilitated 5 focus groups with community members in metro Denver to obtain the feedback of U.S.-born Latino/a teens and parents. Also, two meetings were held with representatives from community-based organizations that work directly with Latino/a adolescents to ask for their feedback regarding these complex issues. The same process was repeated to obtain the feedback of foreign-born Latinas/os, Spanish-speaking community members.

The findings from this first phase provided a wealth of information for consideration when developing initiatives to address Hispanic/Latina teen pregnancy. Input from teens, parents, and community leaders demonstrated a critical need for more leadership from public health agencies in this area including providing funding and technical assistance for programs, and a firm and genuine commitment to work in collaboration with the community to address Hispanic/Latina teen pregnancy. The report from the first phase is attached to this section, after the injury fact sheet.

After the completion of Phase II begun in FY 2005, the results from both phases will be analyzed and compared, yielding possible appropriate programs strategies recognizing socio-cultural differences. The state health department will present the final findings of the Latina Teen Fertility Project to the public, and sponsor a community dialogue to discuss next steps. The project may be expanded (contingent upon funding) by conducting focus groups throughout Colorado to obtain representational statewide data.

Targets and specific plans for follow-up on this measure will be set during FY 2006.

New State Performance Measure 5

The motor vehicle death rate among teens 15-19

The FY 2006 target is 28.0 deaths per 100,000 teens.

According to the Health Statistics Section at the state health department, the motor vehicle death rate among teens age 15-19 in 2003 was 29.0 per 100,000. A fact sheet on deaths and hospitalizations involving teen drivers is attached to this section, following the chart on priorities.

Utilizing the Adolescent Health in Colorado 2003 Report, and building on existing statewide efforts, the Advisory Council on Adolescent Health will meet in the fall of 2005 to develop a work plan to decrease motor vehicle deaths among teens in Colorado. Experts on teen motor vehicle safety will present data to the Council, and state and local and best practices will be identified. We will invite participation from a broad base of stakeholders including the Injury Prevention Section at the state health department; AAA Colorado; representatives from law enforcement, schools, and injury prevention coalitions; parents; and teens. The steps will be incorporated into model work plans for local health departments and used to guide the activities of the state health department's Adolescent Health Program.

New State Performance Measure 6

The percent of mothers smoking during the three months before pregnancy

The FY 2006 target is 15.9 percent.

In Colorado, one out of every eight low birth weight births can be attributed to the fact that the mother was a smoker. In 2003, according to PRAMS data, 18.7 percent of women in Colorado were smokers prior to conception.

The state tobacco program (STEPP) and the Women's Health Section will continue to jointly conduct smoking cessation trainings for prenatal providers. Trainings are offered to prenatal providers from private practice, WIC, Prenatal Plus, Nurse Home Visitor Programs, local health departments, and hospitals on how to implement the 5A's counseling intervention with their patients and incorporate the technique into routine care. Another cessation initiative underway involves physician education through hospital grand rounds. Physicians deliver presentations to audiences of other physicians on tobacco cessation interventions and resources. The Women's Health Section is supporting these efforts by participating in displays and distribution of materials. Assessment and direct counseling for clients will continue at 30 family planning delegate agencies serving 55,000 clients per year and 27 Prenatal Plus agencies serving 3,500 clients per year.

Colorado was selected to participate in the Action Learning Lab: Tobacco Prevention and Cessation for Women of Reproductive Age sponsored by the American College of Obstetricians and Gynecologists (ACOG) and the Association of Maternal and Child Health Programs (AMCHP). The Colorado state team includes members from STEPP, the Women's Health Section, ACOG, Planned Parenthood of the Rocky Mountains, and the March of Dimes. A statewide action plan is being developed to increase collaboration and comprehensive implementation. Through trainings and presentations, we will educate health care providers and provide smoking cessation materials at no charge.

STEPP will promote awareness of the Colorado Quitline (smoking cessation telephone line) among pregnant smokers with television ads that will run statewide using the "You Have the Power" ad from the CDC's media resource center. In addition, several different print ads targeting pregnant smokers will be provided to local health departments for their use in community newspapers.

New State Performance Measure 7

The proportion of all children 2-14 whose BMI is greater than 85 percent weight for height

The target has not yet been set.

Data from the 2004 Colorado Child Health Survey will be analyzed for this measure. Survey questions focus on the health and health behaviors of a randomly selected child in the household (the full format of the survey and all survey questions are attached to Section III F). Parents are asked to actually weigh and measure the child prior to the survey and there are an additional nine questions regarding nutrition.

Data from the 2004 Colorado Child Health Survey indicated that 14.2 percent of children have a BMI greater than 85 percent weight for height. The full survey will be analyzed along with demographic and companion information and a target will be determined.

The state health department's Child, Adolescent and School Health Section, Colorado Physical Activity and Nutrition (COPAN) Program, and WIC Program will work collaboratively with the Healthy Child Care Colorado Project, the Coordinated School Health Program, the Colorado Department of Education and other interested state and local agencies and organizations to develop strategic state and local action steps to address the issue of overweight/obesity among children and adolescents.

In addition, the Child, Adolescent and School Health Section will assess the impact of providing "incentive grants" to local public health agencies in communities whose schools are receiving CDC Coordinated School Health grants. The efficacy and impact of this funding in addressing obesity prevention and healthy lifestyle promotion among the school age population will also be determined.

New State Performance Measure 8

The percent of children who have difficulty with emotions, concentration or behavior

The target for FY 2006 is 28.0 percent.

The target is based on the preliminary estimate of children with difficulties with emotions, concentration or behavior using preliminary 2004 data from the Child Health Survey.

The Child, Adolescent and School Health Section within the Maternal and Child Health Program at the Colorado Department of Public Health and Environment has applied for a grant from MCHB to improve coordination of state mental health prevention, intervention and treatment systems through a collaborative planning process. Recommendations will be prioritized and operationalized through the Prevention Leadership Council, an existing state-level body that is charged with coordinating and streamlining state and federally funded programs that is led by the Colorado Department of Public Health and Environment. Improved state coordination will lead to local services integration, increased access to mental health care, and better mental health outcomes among children, youth and families. If the MCHB grant is not funded, alternate funding will be sought.

New State Performance Measure 9

The percent of center-based child care programs using a child care nurse consultant

The target has not yet been set.

Qualistar Early Learning is a nonprofit organization dedicated to improving child development and age-appropriate learning experiences for all children. It conducts an annual survey of child care providers through the child care resource and referral network throughout the state. In order to obtain

baseline data for this performance measure, the MCH Program plans to sponsor questions on the Qualistar survey to determine how many child care providers are actively using child care health consultants and to ascertain how satisfied the provider is with the consultation services they are receiving.

New State Performance Measure 10

The proportion of high school students reporting binge drinking in the past month

The FY 2006 target is 29.0 percent.

According to the 2003 Colorado Youth Risk Behavior Survey, 29.1 percent of students reported report having drunk five or more drinks in a row (binge drinking).

Colorado has received a $2,350,965 grant from the Substance Abuse and Mental Health Services Administration to advance community-based programs for substance abuse prevention, mental health promotion and mental illness prevention. The program, which is housed in the Alcohol and Drug Abuse Division (ADAD) at the Colorado Department of Human Services, is a collaborative effort between the ADAD and the Prevention Leadership Council. The Director of the Adolescent Health Program will work collaboratively with ADAD, the Advisory Committee and the Underage Drinking Workgroup to develop strategic state and local action steps to address the issue of binge drinking among teen

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	96	98	98	98	98
Annual Indicator	96.3	95.8	97.4	97.5	98.0
Numerator	60092	62900	65344	66834	67920
Denominator	62387	65679	67100	68537	69304
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year.

For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data under the heading 2003 are from calendar 2002.

Notes - 2004

Data under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The target for FY 2004 was 98.0 percent and 98.0 percent was achieved. The target was met.

The data are based on an estimate by the newborn screening laboratory, which does not yet have the ability to match the newborn screens with birth certificates in a timely fashion and therefore cannot give exact figures.

The count of newborns who received a first screening has always been a good estimate, although it is not possible to perfectly distinguish late first screens from true second screens (because of name changes for infants in the first few weeks of life, among other factors). Also it is not possible to electronically link birth certificate information with newborn screening information in a timely way. The electronically integrated Newborn Evaluation Screening and Tracking (NEST) system, funded by a CDC EHDI (Early Hearing Detection and Intervention) grant and currently under development, will allow matching of newborn screening data with electronic birth certificate data. This matching will improve precision in determining the number of Colorado live-born infants who have received at least one newborn screen. This same matching process should allow determination of what proportion of first screen infants receive a second screen as well. Work on the system continued throughout the fiscal 2004 year.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of Newborn Evaluation Screening and Tracking (NEST) system linking screening and electronic birth certificate data.				X
2. Screening of all occurrence births in the state for seven conditions.			X	
3. Evaluated Supplemental Screening Program to determine if proportion of birth cohort screened increased.				X
4. Worked on linking electronic birth certificate with laboratory newborn screens to determine precise proportion screened.				X
5. Support of tandem mass spectrometry at the University of Colorado Health Sciences Center.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for FY 2005 is 98.0 percent.

The program anticipates being able to measure the proportion of newborns screened using the NEST system by the fall of 2005.

The effort to advance newborn screening by tandem mass spectrometry has also moved forward. The number of children screened by the voluntary program at the University of Colorado Health Sciences Center has increased from several hundred to approximately 12,600 (about 18.0 percent of the birth cohort) between FY 2003 and FY 2005. In addition, we were able to secure support from the department's Executive Director and the Governor to pursue statewide implementation of tandem mass spectrographic screening (expanded newborn screening). This initiative has been favorably received by the legislature. Approval for the necessary newborn screening fee increase to support the state laboratory in pursuing establishment of the new technology is expected by January 2006. The measure has been signed by the Governor. Advance work to establish the new testing and follow-up protocols for newly identified conditions began in July of 2005.

c. Plan for the Coming Year

The target for FY 2006 is 98.0 percent.

With the electronically integrated NEST system development expected during FY 2005, we anticipate that we will be able to analyze first and second screens accurately for calendar 2005 and therefore provide a more precise count for this performance measure for FY 2006. With the additional information this system will provide, we will be able to set appropriate targets for future years.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55	55
Annual Indicator			57.4	57.4	57.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.4	57.4	57.4	57.4	57.4

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported for 2003 are the same SLAITS data first shown for 2002. No update is available.

Notes - 2004

Performance objectives have been set at the baseline rate for Colorado established by the national survey of children with special health care needs (SLAITS) conducted in 2001. These data were collected to assess the rate at which this performance measure was met in each state. Currently, there is not any recommended annual increase above the baseline rate for this performance measure. No new state data are available to assess a change in this performance measure until after the next national survey is conducted in 2005-2006. Since 2002, Colorado has worked to establish appropriate indicators and data sources to assess this performance measure annually. Until indicators and data sources are established to measure this performance measure regularly, the objective for this performance measure will remain at the baseline rate.

a. Last Year's Accomplishments

The 2004 target was 55.0 percent and the most recent data indicates that 57.4 percent has been achieved. This is baseline information and achievement of the target for 2004 cannot be determined. More recent data are not available.

The Health Care Program for Children with Special Needs (HCP) employs a Family Consultant who provides ongoing advocacy at policy levels, and who develops community networks of parent advocates through the HCP Parent Coordinators employed by the 14 regional offices.

One of the goals of the Colorado Medical Home Initiative is that parents/families will be able to recognize and advocate for a medical home for their child, thus improving their involvement, advocacy and satisfaction with services. Through the Medical Home Learning Collaborative, the parent practice partnership has been promoted. Each participating medical practice identified one or two parents to meet with a physician champion and another interested member of the office staff. Regular meetings were used to design objectives and activities to improve parent satisfaction and participation within that practice. The Medical Home Initiative developed a strategic plan to address the barriers to family participation and satisfaction.

Family participation and satisfaction is so important that these objectives fall under other outcome areas as well. Another objective in the medical home strategic plan included a partnership with Family Voices Colorado, a state chapter of the national Family Voices advocacy organization, to implement a Children's Medical Services grant project. The grant was used to build local community capacity to better understand and navigate the public and private health care system. The Family-to-Family Health Information Network (F2F) provided training for HCP family coordinators, families, providers, and community partners on topics such as insurance; national, state and local systems that serve children with special health care needs; and navigating the health care system and advocacy. HCP family coordinators were required to attend F2F trainings. Greater family participation and satisfaction at the local level should result from this effort.

Four F2F trainings were included in the grant proposal, but their success led to the offering of three additional trainings, one in monolingual Spanish. These trainings provided the HCP regional offices with the opportunity to reach out to families that otherwise might not have recognized that HCP could help their child.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. Coordinated with families, agencies, and faith-based organizations.				X
2. Worked with Colorado Family Voices to track parent satisfaction with services.		X		
3. Continued to provide financial and education support to parents.			X	
4. Launched public education outreach campaign regarding services available through the Health Care Program for Children with Special Needs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 57.4 percent.

The national SLAITS survey will start collecting data this year, but the data will not be ready to be analyzed until 2007 or 2008. Currently data are not available to determine if this target has been met.

The Measuring and Monitoring data group formed a data workgroup to specifically address this outcome measure. This group met to determine indicators for measuring this outcome in Colorado.

The Medical Home Initiative strategic plan is being implemented. One of the goals is to assure that families understand and can advocate for the medical home approach. The Medical Home Learning Collaborative, as part of the Medical Home Initiative strategic plan, continues to meet throughout the year to develop "clinical laboratories" that will teach elements of the medical home approach and implement the parent practice partnership across the state. The Initiative remains focused on further refining the clinical laboratory for medical homes within two existing practices.

Also as a part of the Medical Home Initiative strategic plan, the Family-to-Family Health Information Network (F2F) continued to offer trainings, increase participation, and improve their curriculum. HCP plans to use the administrative and attendee satisfaction survey data to assess the impact on the community of such training. HCP also supports the train-the-trainer model utilized by the F2F training. HCP expanded the curriculum to include new topics that will assist families in navigating the health care system. In addition, all Regional HCP Family Coordinators received more intense education in the train-the-trainer format.

A Family Satisfaction Survey was created during this fiscal year. Data from these surveys are being compiled to measure family satisfaction at the local level.

The Child Health Survey's first year of data collection is complete and will be analyzed in the summer and fall of 2005. The data from the Survey will address this outcome measure and will be used to compare children with and without special health care needs. The information will be used in making program decisions regarding how to best improve family satisfaction and decision making in the state of Colorado.

A public education campaign to "re-brand" the state health department's Health Care Program

for Children with Special Health Care Needs was started this year and will continue into the next. The campaign will include information about the work of parent coordinators and the medical home approach used to strengthen family satisfaction and participation in decision making. This information will assist HCP in making programmatic decisions and changes to next year's strategic plan.

c. Plan for the Coming Year

The target for FY 2006 is 57.4 percent.

The Medical Home Initiative strategic plan will continue to be implemented to assure families understand and can advocate for a medical home approach. As part of this plan, the Medical Home Learning Collaborative will continue to meet. Members will define medical home qualities, including the parent practice partnership, to implement in other practices across the state. Information regarding barriers and successes in the previous year will influence the work of this group.

The state Family/Parent consultant will promote parent leadership and participation around Colorado. She will provide public training in family advocacy and outreach to nontraditional organizations and agencies.

Also a part of the Medical Home Initiative strategic plan, the Family to Family network, will conclude its training efforts. Administrative and satisfaction data will be analyzed to assess family satisfaction and identify education gaps and areas for improvement.

The state's Health Care Program for Children with Special Needs will continue to acquire Information through the annual report document (HERMAN) from all the regional offices regarding their progress toward achieving goals and national performance measures. (The HERMAN template is attached to this section). Data from 2005 will be analyzed in 2006. Community encounters will be compared to the previous year and decisions will be made on how best to increase family satisfaction and support decision making with families at the local level.

Colorado received 15 points out of 18 on the MCH family participation score. Colorado is attempting to correlate the numerous activities of the family coordinators with family satisfaction and participation through analyzing local family satisfaction surveys. This will then be the basis for a standardized state family satisfaction survey for use at the local level. Data collection and analysis to monitor family satisfaction and link programmatic changes to satisfaction will continue. This will allow longitudinal assessment of family participation and satisfaction in all communities.

The 2005 Colorado Child Health Survey data will be available in the fall to analyze and compare to the previous year. These data will be disseminated through the HCP Web site and the Measuring and Monitoring data group, and will be utilized for program planning and decision making. The Measuring and Monitoring data group will continue to meet with stakeholders to address data collection and collaboration for this outcome.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		18		50	50
Annual Indicator		47.4	51.7	51.7	51.7
Numerator		110228			
Denominator		232737			
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	51.7	51.7	51.7	51.7	51.7

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported for 2003 are the same SLAITS data first shown for 2002. No update is available.

Notes - 2004

Performance objectives have been set at the baseline rate for Colorado established by the national survey of children with special health care needs (SLAITS) conducted in 2001. These data were collected to assess the rate at which this performance measure was met in each state. Currently, there is not any recommended annual increase above the baseline rate for this performance measure. No new state data are available to assess a change in this performance measure until after the next national survey is conducted in 2005-2006. Since 2002, Colorado has worked to establish appropriate indicators and data sources to assess this performance measure annually. Until indicators and data sources are established to measure this performance measure regularly, the objective for this performance measure will remain at the baseline rate.

a. Last Year's Accomplishments

The 2004 target was 50.0 percent and 51.7 percent was achieved. This is baseline information from 2001 and achievement of the target cannot really be determined for 2004.

HCP is currently operationalizing definitions of medical home and children and youth with special health care needs. Secondary data sources may be used to measure medical home before 2007, when the national survey for children with special health care needs will be ready for analysis.

The Colorado Medical Home Initiative began in 2000 to address the national outcome measure "All children will receive ongoing comprehensive care within a medical home." The Title V HCP program took the lead to design a structure and infrastructure for this initiative. A strategic planning team of five state HCP staff has developed four long- term goals, a "vision" for medical homes in Colorado, and interagency annual plans that are reviewed by a medical home advisory board. This advisory board, which is made up of a broad array of consumers

and public and private organizations, also provides needs and resource information that assists in meeting or changing the medical home strategic plan.

The Medical Home Learning Collaborative is only part of the broader Colorado Medical Home Initiative. The Initiative represents Title V's coordination of efforts to assure primary care and a medical home approach in Colorado, especially for children and youth with special health care needs.. The Board advises HCP on resources, as well as state and national needs to meet the Initiative's annual strategic plan.

Infrastructure-building around the concept of a medical home was a priority during this past year. Qualitative information provided by local HCP offices and other providers indicates that there is a statewide decrease in providers serving children and youth with special health care needs, especially providers who accept Medicaid and Child Health Plan Plus.

The Health Care Program for Children with Special Needs also participated in the Measuring and Monitoring Community-Based Systems of Care technical assistance project, which helped HCP identify relevant medical home data available in Colorado.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyzed Peregrine database of providers for insurance plans.				X
2. Coordinated public health/HCP care coordination with primary care practices in HCP local regions.			X	X
3. Worked with the Colorado chapter of the American Academy of Pediatrics to increase reimbursement for primary care providers, and help them with billing information.				X
4. Increased dissemination of statistics and cost data to legislators, families, agencies and providers.				X
5. Worked with the Medical Home Learning Collaborative.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 51.7 percent.

SLAITS data will be collected this year and will be available for analysis in 2007-2008. We may not be able to measure progress toward the target in FY 2005.

Despite numerous challenges, the Colorado Medical Home Initiative, in collaboration with the local Chapter of the American Academy of Pediatrics, increased reimbursement for primary care providers. These reimbursement increases are essential to building medical homes.

Through the Medical Home Advisory Board, the state health department's Health Care Program for Children with Special Needs continues to work with other agencies in the state to address the issue of medical home in Colorado.

The Measuring and Monitoring Community-Based Systems of Care group made a commitment to acquire information to measure outcomes for children with special health care needs and medical home. The group established a medical home data workgroup. The group's main goal is to determine indicators for medical home and to select and use a definition for identifying a special health care needs child or youth.

Having a medical home is the first step in having a usual source of care. Information collected through the HERMAN annual report indicated that 55 percent of the HCP caseload has a usual source of care.

A public education campaign was undertaken to increase awareness and knowledge of HCP and the services provided. Information provided by the campaign will be incorporated into state program infrastructure-building activities to increase the number of children with medical homes in Colorado.

The Health Care Program for Children with Special Needs purchased access to the Peregrine database, which contains information regarding providers and the type of insurance they accept in their practice. Provider information and other data will be utilized for planning the building of medical home infrastructure and participation.

c. Plan for the Coming Year

The FY 2006 target is 51.7 percent.

The Colorado Medical Home Initiative will continue to direct efforts to build community capacity by increasing the number of providers and families with children with special health care needs that participate in medical homes.

The Measuring and Monitoring data group will begin data collection on the number of children who have a medical home and the quality of medical homes utilizing the definition created by the Medical Home Advisory Board.

HCP will continue to acquire information from all the regional offices regarding their progress toward national performance measures through the HERMAN document. These data will be available for analysis in the fall of 2006. These data will provide HCP with information about local medical home infrastructure-building activities, barriers, and resources.

The Peregrine database will be used to identify practitioners able to provide medical homes for both children and youth with special health care needs and the types of insurance they accept. The public education campaign will continue through 2006 to raise awareness of the medical home concept statewide.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55	55
Annual Indicator			58.2	58.2	58.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	58.2	58.2	58.2	58.2	58.2

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported for 2003 are the same SLAITS data first shown for 2002. No update is available.

Notes - 2004

Performance objectives have been set at the baseline rate for Colorado established by the national survey of children with special health care needs (SLAITS) conducted in 2001. These data were collected to assess the rate at which this performance measure was met in each state. Currently, there is not any recommended annual increase above the baseline rate for this performance measure. No new state data are available to assess a change in this performance measure until after the next national survey is conducted in 2005-2006. Since 2002, Colorado has worked to establish appropriate indicators and data sources to assess this performance measure annually. Until indicators and data sources are established to measure this performance measure regularly, the objective for this performance measure will remain at the baseline rate.

a. Last Year's Accomplishments

The target for 2004 was 55.0 percent and 58.2 percent was achieved. This is baseline information and achievement of the target cannot be determined for the years since the SLAITS original survey.

JFK Partners, Colorado's University Affiliated Program for individuals with developmental and other disabilities, their families, and communities, reported that public and private insurance is not being fully utilized for children from birth to three years. Instead, some of the covered benefits are being provided through state Early Intervention dollars. These same data reported that within families with insurance, 25 percent are considered underinsured.

The state health department's Health Care Program for Children with Special Needs' annual End-of the Year Report and MCH Plan (HERMAN) document provided the state program with information regarding regional progress toward contract measures, infrastructure building activities, and performance measures. Information collected in 2003 became ready for analysis in the summer of 2004.

The Measuring and Monitoring data group is meeting with local stakeholders to identify data

sources to use to measure this outcome for children and youth with special health care needs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained access to public and private health insurance resources through local outreach activities.				X
2. Provided access to specialty care in rural service areas through HCP's clinic outreach program.		X		
3. Continued to analyze available data on why children are uninsured through collaboration with Colorado Children's Campaign and Family Voices Colorado.				X
4. Analyzed Colorado Child Health Survey insurance data.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for FY 2005 is 58.2 percent.

SLAITS data is currently being collected, but will not be ready for analysis until 2007-2008. No new data are available to assess if this target is being met.

Because of the capping of enrollment in the Child Health Plan Plus program between November 2003 and June 2004, the Health Care Program for Children with Special Needs (HCP) questions if the SLAITS data are representative of the recent state of insurance in Colorado. The next SLAITS survey is starting in 2005 and data will be available for analysis in 2007-2008.

The annual HERMAN document will provide information regarding insurance status of families of children with special needs who participate in HCP. While the regional offices can only gather data from enrolled families, they will be able to estimate the proportion of families of children with special health care needs who have insurance and the type of type of insurance. Last year, 83 percent of HCP clients reported having some type of insurance. Within the HCP caseload, there were over 1,500 clients who sought care coordination for insurance concerns. There were 257,167 children under 22 years old in Colorado enrolled in Medicaid as of December 2004. However, we do not know how many of these children and youth have special health care needs.

The Measuring and Monitoring data group remains committed to gathering information from sources around the state to measure outcomes for children with special health care needs. This year the group established an insurance data workgroup which will define measurable indicators for insurance coverage. They will also identify indicators for "adequate" insurance for children and youth with special health care needs. The group participates in the state health department's access to care workgroup that addresses insurance with an emphasis on the maternal and child health population.

The Colorado Child Health Survey began collecting data in January 2004 and will provide information regarding insurance coverage for all children in Colorado. Because the SLAITS survey will not be conducted again until 2005, this survey is expected to yield data that should estimate the number of children with special health care needs in the state with insurance and what type. Data will be disseminated through the HCP Web site, the MCH health status report, and the Measuring and Monitoring data group.

c. Plan for the Coming Year

The target for FY 2006 is 58.2 percent.

SLAITS data will be available for analysis in 2007-2008.

The annual HERMAN document will provide insurance information from all the regional offices in Colorado. These data will be limited to those families with children with special health care needs who access care coordination through the state program. Data from 2005 will be analyzed and compared to 2004 data. The program will access progress related to insurance coverage affecting HCP-enrolled children. Colorado Child Health Survey data will also be available.

The Measuring and Monitoring data group will continue to work with Part C, Medicaid, and Family Voices and their insurance projects, as well as with other stakeholders, to utilize all possible data to get the best insurance profile for families with special health care needs in Colorado.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				75	75
Annual Indicator			77.4	77.4	77.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77.4	77.4	77.4	77.4	77.4

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported for 2003 are the same SLAITS data first shown for 2002. No update is available.

Notes - 2004

Performance objectives have been set at the baseline rate for Colorado established by the national survey of children with special health care needs (SLAITS) conducted in 2001. These data were collected to assess the rate at which this performance measure was met in each state. Currently, there is not any recommended annual increase above the baseline rate for this performance measure. No new state data are available to assess a change in this performance measure until after the next national survey is conducted in 2005-2006. Since 2002, Colorado has worked to establish appropriate indicators and data sources to assess this performance measure annually. Until indicators and data sources are established to measure this performance measure regularly, the objective for this performance measure will remain at the baseline rate.

a. Last Year's Accomplishments

The FY 2004 target was 75.0 percent and 77.4 percent was achieved. This is baseline information and achievement of the target cannot be determined for 2004.

In 2001, data available from the first national State and Local Area Integrated Telephone Survey (SLAITS) reported that 77.4 percent of families with children with special health care needs felt that community-based systems of services were well organized and they could access them easily. This is considered to be the baseline figure, and no more recent data are available.

Through the Measuring & Monitoring data group and the Medical Home Initiative, the Health Care Program for Children with Special Needs (HCP) identified important representatives from other agencies that provide data on children with special health care needs in Colorado. The Part C Memorandum of Understanding Group and the Medical Home Advisory Group were important resources for identifying systems issues at the state and local levels. Information from these groups allowed the state program to build community resource networks and relationships to improve the ease of use of such systems by families.

HCP has built and maintains a significant community resource network of specialty clinics throughout the state, mainly in rural and frontier areas. HCP sponsors pediatric specialty, Diagnostic and Evaluation, and genetics clinics. Over 300 clinics are held each year to accommodate nearly 3,000 client visits.

The annual End-of the Year Report and MCH Plan (HERMAN) document provided information regarding community-based service systems throughout Colorado. Available resources are listed in the areas of: relationships; how systems are working; and proposed programs to increase the number of resources available for families of children and youth with special health care needs. Data from HERMAN were analyzed and gaps in services were identified leading to a number of projects described below.

The program replicated a model that utilizes the support of community partners, including the local university, to provide respite to families who have children and youth with special health care needs from the ages of 6 months to 21 years old. Based on a successful model called The Adventure Center, this program has successfully supported families for over five years. Project training was conducted and three to four communities launch the program. The program convened partners to establish a task force called Inclusive Communities in Faith. The primary mission of this task force is to provide awareness, education, and guidance to faith

communities, enhancing their ability to support individuals with disabilities and their families. This group offers technical assistance and community building strategies to faith communities.

A hearing aid loaner bank has been established to serve the entire state. The bank is a partnership between HCP and the Colorado School for the Deaf and Blind.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to develop a system of services and supports for CSHCN through state and local agencies.				X
2. Collected and analyzed data to ascertain availability of care for CSHCN from other partners.				X
3. HCP providers provided medical consultation to agencies that provide coordination services.	X			
4. Medicaid EPSDT Outreach played a role in building medical homes and assuring adequate services.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 77.4 percent.

The Measuring and Monitoring Data Group formed a workgroup to address the issue of measuring community-based systems of care. The first meeting was set for summer and will continue through the year.

The specialty, Developmental and Evaluation clinics, and genetics clinics are developing a data collection system to measure family satisfaction and clinic data. These data will be analyzed in 2006 and utilized for program assessment and planning.

The annual HERMAN document will provide information regarding community-based systems of care and how well they are serving children who participate in the Health Care Program for Children with Special Needs (HCP).

The Integrated Referrals and Information System, HCP's case management database, reported over 3,100 community encounters and over 1,600 referrals made to other agencies for contract year 2003-2004. The most frequent reason documented for community encounters was capacity building. Community encounter information is being improved to allow better data collection and more in-depth analysis of the state effort to meet this outcome.

The Adventure Center Respite Program was replicated in other areas across the state. The state's HCP Family Coordinator was invited to a statewide mental health awareness training for communities of faith to discuss the needs of children and youth with special health care needs. The first rural feeding clinic was conducted and will be expanded as resources are available.

The DMH loaner bank and lending library system will develop a state-wide webbased site for all durable medical equipment loaner banks to list their inventories. This system will be voluntary and open to all the sites.

Colorado recently passed legislation setting aside a certain portion of money from insurance settlements of motor vehicle accidents to fund a Traumatic Brain Injury Trust Fund. HCP began working with the Traumatic Brain Injury endowment in 2004, and plans to offer care coordination to children and youth under 21 who experience traumatic brain injuries. The project began in July and will continue through an annual contractual agreement with the Colorado Department of Human Services. This project allows HCP to work with new partners and to provide care to a previously unserved or underserved population.

Building infrastructure and identifying barriers to provider services will not only increase the number of families that are working with the state program, but will afford better transition outcomes for all children with special health care needs. Many stakeholders are involved with building easy to use community-based systems of care including Part C, EPSDT, and others.

A public education campaign about children with special health needs was begun. The campaign will increase awareness of HCP program services and facilitate collaboration among other agencies and systems.

c. Plan for the Coming Year

The FY 2006 target is 77.4 percent.

The Medical Home Learning Collaborative, the Measuring and Monitoring Data Group, the Transition Work Group, the Community Access To Child Health Grant Advisory Group, and the Champions for Progress Center will meet to address the issue of community-based services. This issue is at the heart of many of the other national performance measures and will continue to be both a family and infrastructure-building activity.

Data about specialty clinics will be available for the first time. Analysis will begin and the information will be used for program improvement and planning.

The annual HERMAN document will provide information for each region regarding community-based services, resources, and local strategic plans for systems-building efforts. Year 2005 information will be analyzed and used for program planning.

Traumatic Brain Injury (TBI) care coordination data will be analyzed and used to improve the TBI program and care coordination around the state.

The public education campaign will continue into 2006.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**

Annual Performance Objective			3.3	3.3	8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	12	14	17	19

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported for 2003 are newly available SLAITS data, previously unreported. The same figures are shown for both 2002 and 2003 (data are from the 2000-2002 survey).

Notes - 2004

The data reported for 2004 are the same SLAITS data first shown for 2002. No update is available.

a. Last Year's Accomplishments

The FY 2004 target was 8.0 percent and 5.8 was achieved. This is baseline information and achievement of the target cannot be determined.

Data available from the first national State and Local Area Integrated Telephone Survey (SLAITS) from 2000-2002 reported that 3.3 percent of youth with special health care needs received all needed services to transition successfully into adult life. These data were collected for children up to age 18 years old and therefore do not represent all of the youth in Colorado, who are classified as 14 to 21 years old.

The state health department's Health Care Program for Children with Special Needs (HCP) publishes an annual End-of the Year Report and MCH Plan (HERMAN). The HERMAN document collected information from all regional HCP offices regarding transition issues.

The Measuring and Monitoring Data Group met regularly and collected information on barriers to and issues around transition for youth with special health care needs. This group bought rights to use the Peregrine database, which provides information on Colorado providers and whether or not they accept Medicaid and/ or Child Health Plan Plus insurance. These data and other information were analyzed to produce the best profile of issues affecting youth transition in Colorado.

The state program participates in a Community Access To Child Health (CATCH) grant. Using focus groups in three areas of the state, this grant assesses physician provider capacity issues and their relationship to youth aged 14 to 21 with special health care needs. These youth should be transitioning from pediatric to adult health care providers; from student to work or vocational status; and from family insurance to their own insurance. The CATCH grant was expanded with the addition of a Champions for Progress Transition grant to further assess needs in Colorado.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with local Health Care Program offices concerning their ideas about youth to adult transition.		X		
2. Worked with local adult specialty and primary care providers who see the youth who attend HCP clinics.		X		
3. Worked with the Community Access to Child Health grant to focus on transition.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 10.0 percent.

SLAITS data are being collected but will not be ready for analysis until 2007-2008. Currently there are no new data to use to assess this outcome. We anticipate that input to the survey design given this year from the Health Care Program for Children with Special Needs (HCP) and MCH will result in survey questions that address this issue more comprehensively than in the first SLAITS survey completed in 2001.

For contract year 2003-2004 the HCP caseload included over 1,400 youth with special health care needs -- 15 percent of the total caseload. Out of all the concerns marked for care coordination about 1 percent of their families specified transition as a concern.

The Measuring and Monitoring Data Group established a workgroup to address issues of data collection regarding transition in Colorado. This group met throughout the year and identified which data will need to be collected to adequately measure the issues of youth with special health care needs transitioning to adulthood in the state.

HCP participated in the Community Access To Child Health grant, which addresses the issue of transition for youth with special health care needs ages 14 to 21 years. The grant utilizes a broad community-based partnership to develop strategies to effectively implement project planning. By utilizing this community partnership, HCP not only facilitates the completion of this grant, but has a voice in the activities centered around transition and access to care for all youth with special health care needs in the state. Data collection will be completed this year and analysis will begin in the first part of FY 06.

c. Plan for the Coming Year

The FY 2006 target is 12.0 percent.

Although data from SLAITS was collected during calendar 2005, the results will not be available until 2007-2008.

The Measuring and Monitoring Data Workgroup for Transition will continue to meet and incorporate transition data into its meetings. Building infrastructure and planning around medical home and community-based systems of care will help youth with special health care needs transition into adult life successfully. Through this group, HCP will continue to collaborate, incorporate new members, and address issues of transition.

Data from the Community Access To Child Health grant will be analyzed and disseminated. These data will be used to address program improvement and planning for transitioning youth in Colorado.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	80	84	86	88
Annual Indicator	74.8	73.9	75.4	64.3	67.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

The FY 2002 data are from the National Immunization Survey (NIS) for 2001 and are the 4:3:1:3 series among children 19-35 mos published in the MMWR, Vol. 51, No. 30, pages 664-666.

Notes - 2003

The 2003 data are from the National Immunization Survey for calendar 2002 and are the 4:3:1:3 series among children 19-35 months of age.

Notes - 2004

The 2004 data are from the National Immunization Survey for calendar year 2003 and are the 4:3:1:3:3 series among children 19-35 months of age.

a. Last Year's Accomplishments

The FY 2004 target was 88.0 percent and 67.5 percent was achieved. The target was not met.

For the last two quarters of 2003 and the first two quarters of 2004, the 4:3:1:3:3 series rate for two-year-old children in Colorado was 70.9 percent, an increase from the previous year. The 4:3:1:3:3 series specifies 4 doses of DtaP: 3 doses of polio: 1 dose of MMR (measles, mumps, and rubella): 3 doses of Hib: and 3 doses of Hepatitis B.

Colorado achieved 90 percent or greater for the 3 DTaP shots (94.4 percent), 3 Hib shots (90.7 percent), and 3 Hepatitis B shots (90.4 percent). Colorado attained a rate of 76.6 percent for the 4th DTaP, up from 61.1 percent for the same time period last year. This specific immunization is largely responsible for Colorado's overall low immunization rate.

Nationally, the 4:3:1:3:3 rates are 77.9 percent, while Colorado's rate for the same time period was 70.9 percent. Colorado has seen an overall increase in its 4:3:1:3:3 rate for our immunization coverage of 19-35 month olds. Problems that contributed to Colorado's inability to meet the goal include geographic constraints, variability in the amount of financial support, an insufficient number of health professionals, the mobility of the population, and limited ability to perform reminder recall.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured that VFC/AFIX visits are conducted in private provider offices and community health centers.				X
2. Used GIS to map risk factors for low immunization rates to identify areas to target activities.				X
3. Began developing process evaluation indicators for use to measure immunization practices statewide.				X
4. Continued a collaborative strategic planning process involving internal and external partners and stakeholders.				X
5. Improved immunization baseline measurements throughout the state using process evaluation indicators based on nationally recognized best practices.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 90.0 percent.

Again in FY 2005, the Immunization Program received funding from the Health and Human Services Preventive Health Block Grant to fund local health agencies that were expanding clinical access and improving immunization services. . Additional funds for service delivery contracts are supported by a grant from CDC's National Immunization Program.

For the first time in several years, the Immunization Program received State general fund

monies ($476,000) to support clinic outreach, pockets of need work, and a public information campaign. The majority of these funds are being used by 22 local health agencies to conduct regularly scheduled outreach clinics in non-traditional venues. The project is to establish clinics in areas where children are at high risk for under-immunization or no immunization. Children 12-24 months old are the target group, with particular emphasis on the 4th DTaP.

Agreements have been established with local health agencies interested in performing quality assurance site visits in provider offices participating in the Vaccines for Children (VFC) program. These agreements enable the VFC program to maximize the number of participating provider offices receiving annual visits.

Other activities include a project that maps comparison data using maternal risk factors as surrogates for low/no immunization coverage, with other data from a large county health department's registry, and census data for children living at or below 200% of poverty. Concurrently, data from the VFC program and Medicaid are being used to compare the distribution of VFC providers vs. Medicaid-only enrolled providers. Analysis of these data with the distribution of children at risk of low/no immunizations will help to identify factors contributing to low coverage rates.

Work continues on the identification of various outcome evaluation indicators. Analysis of Medicaid data indicate that 25%of children covered by Medicaid are up-to-date on immunizations. Development of a research study to determine the accuracy of this rate is underway and will provide valuable information about Colorado children. Data are being collected from schools and daycare centers through on-site data abstraction.

The development of process evaluation indicators based on nationally recognized best practice data has begun. This indicator measures the number of providers who routinely use any reminder/recall effort. Data are being collected to determine baseline measures for specific evaluation indicators. Subsequently specific strategies will be developed to improve baseline measurements.

The Legislature approved renewal of funding to support local health agencies engaged in community-based outreach. Additionally, the Governor approved legislation to support expansion of the Colorado Immunization Information System, and legislation that allows the state health department and its contractors to do reminder/recall activities.

c. Plan for the Coming Year

The FY 2006 target is 90.0 percent.

Plans include developing a collaborative, strategic, multi-stage planning process that will integrate internal partners, external organizations, external providers, and external organizations and stakeholders. This dynamic process will involve identification of realistic goals and strategies for improving childhood immunization rates across the state. The focus of different stages will include stakeholder barrier analysis, managed care analysis, VFC provider review, targeted surveys, and targeted focus group meetings. A steering committee will meet regularly.

To increase the VFC program's quality assurance activities, three regional part-time public health nurse consultants will be hired for the northeast, northwest, and southeast parts of the state, areas that currently are not covered through existing agreements.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	29.5	29.5	29	29	28
Annual Indicator	29.9	29.4	25.4	25.9	24.6
Numerator	2579	2612	2340	2439	2304
Denominator	86316	88903	91964	94120	93810
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24	23.5	23	22	21.5

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data under the 2003 heading are from calendar 2002.

Notes - 2004

Data under the 2004 heading are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 28.0 per 1,000 births and 24.6 was achieved. The target was met.

Since 1992, the teen fertility rate in the state has dropped by one-third, from a high of 36.3 births per 1,000 teens. The duration of this decline, as well as its magnitude, is unprecedented.

A number of factors are contributing to the decline. Family Planning services, including information about abstinence, are available statewide through the Title X family planning program.

Title V funding for abstinence (the Colorado Abstinence Education Program) supported eight local abstinence education programs, a statewide social marketing campaign reaching 110,000 adolescents ages 12-18, and four curriculum trainings to 100 educators. The Friends First Quinceanera abstinence education project was piloted in March 2004 and launched in September 2004 in Weld County, Adams County and the cities of Brighton and Longmont. The program served 82 teens and 51 adults.

In addition to abstinence promotion, an increase in the use of contraception among teens who are sexually active has taken place over the past decade. In 2003 condom use reached 68 percent, 21 percent of sexually active female students were using birth control pills, and an additional 8 percent were using an injectable contraceptive.

Another factor in the overall decline is reduced exposure to the risk of pregnancy. In 2003 in Colorado 39 percent of students reported ever having sexual intercourse, a decrease from 47

percent in 1995.

During FY 2004, an exploratory study was undertaken on the factors related to Latina teen pregnancy. A consultant was hired in March 2004 to conduct focus groups and meetings with U.S.-born Latino/a teens and Latino parents, as well as with community members and organizations in metro Denver serving the local Latino community (Latina Teen Fertility Project, Phase I). An important theme emerging from these Phase I focus groups was the array of conflicting social and cultural values facing Latinos. Many of the teens talked about existing in two cultures, their parents' culture and the general American culture. This conflict presents a unique set of challenges in addressing this problem and distinguishes Latinos from other teen groups.

Local health department efforts around this measure included the following: in Boulder County, implementation of the Home-Based Contraception Program, and in El Paso County, the health department facilitated "delayed exams," where young women desiring birth control whose pregnancy tests were negative received a contraceptive method before they obtained a gynecological exam. In Pueblo County, efforts focused on a community approach including a public awareness campaign around adolescent sexuality. And in Weld County, the health department worked with parents on curricula that emphasized abstinence.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported Title X work to target family planning services to teens across the state.	X			X
2. Supported school-based health centers, which address high-risk behavior among teens.	X			X
3. Focused on Latina teen fertility by identifying stakeholder attitudes and beliefs about the issue.				X
4. Worked with Hispanic organizations and stakeholders to identify best practice strategies to decrease Latina teen fertility.				X
5. Continued the Abstinence Education Program.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 24.0 births per 1,000 teens.

This is a sharp reduction from last year's target of 29.0, but it is in line with an expectation that the low target attained in calendar 2002 will continue to fall. While it is reasonable to anticipate continuing declines for the Black and White non-Hispanic populations, the birth rate among White Hispanic teens is the driving factor in the overall rate. In 2003, 6 out of 10 births in the 15-17 year-old age group were White Hispanic births. What happens in this subgroup is critical to the level and direction of the rate, and what will happen is not clear at this time.

A recent analysis revealed that while fertility rates for Hispanic teens who were born in Mexico

were double those for U.S.-born Hispanic teens, Mexico-born Hispanic teens contributed only 1 out of every 5 Hispanic teen births in Colorado. The rate among U.S-born Hispanic teens was also higher than for any other U.S.-born ethnic or racial group. The teen birth rate in 2000 (the year when both Census population data and birth data were available) was 29.9 overall; 46.6 for Black teens, 17.3 for White non-Hispanic teens, and 77.8 for Hispanic teens. For U.S.-born Hispanic teens the rate was 64.8, and for teens born in Mexico, Central America, and South America, it was 131.1. The birth rate of the U.S.-born Hispanic teens, coupled with the high number of U.S.- born Hispanic teens, yielded a high overall birth rate for Hispanic teens that was mainly due to the births among the U.S.-born teens.

The same contractor for the Latina Teen Fertility Project Phase I done last year was hired early in calendar 2005 to conduct five more exploratory focus groups in metro Denver (Phase II) with foreign-born Latinos/as and Spanish-speaking community members. As in Phase I, the contractor also conducted two focus groups with key community representatives. Focus group participants were foreign-born and Spanish-speaking, and included Latinas who had babies as teenagers or who were currently pregnant; Latinos who fathered babies as teenagers; Latinos and Latinas who have not had pregnancies or babies as teens; Latinos and Latinas whose children were/are teen parents; and Latinos and Latinas whose children have not been pregnant nor are teen parents. The focus groups were completed in June 2005 and a report will be submitted by the end of FY 2005.

During FY 2005, the Colorado Abstinence Education Program continued the funding of eight programs providing curriculum-based abstinence education at the community level. A social marketing firm was retained to develop a strategic marketing plan for the 2004-2007 campaign to promote abstinence. Mini-grants for innovative strategies were awarded to seven local partners for development and implementation of program components to specifically address underserved and nontraditional audiences. Two of these grants focus on developing materials specific to the Hispanic population, particularly monolingual parents.

c. Plan for the Coming Year

The target is 23.5 births per 1,000 teens.

This new lower goal is set based on the experience of the recent decline in fertility and assumptions that the decline will continue. Efforts to reduce Latin teen fertility in particular involve the Latina Teen Fertility Project. Findings from Phase I and Phase II of the project will be released to the public via community meetings during FY 2006. Plans are also being made to present the findings at conferences, trainings, etc. as a means of stimulating conversation and ideas on how to address Latino/a teen fertility issues, based on what was learned. In addition, the Latina Teen Fertility Project is meeting with others who have related projects or interests as a way to coordinate our efforts.

The Colorado Abstinence Education Program is working with the Catholic Diocese to support staff training and implementation of curriculum-based, non-sectarian abstinence education in a multi-session format as part of rites of passage such as Holy Communion and Quinceanera. In addition, the program will sponsor a statewide training in the Friends First Quinceanera curriculum and provide scholarships to 10 local partners. The social marketing agency is developing parent and teen collateral materials that will be translated into Spanish with FY 2006 abstinence funding.

We will continue to support Title X work providing family planning across the state. In addition, Title V will provide support to school-based health centers, which address high-risk behavior among teens. The American Journal of Public Health has accepted an article for publication written by two staff members of the Prevention Services Division. "Just a Coincidence? The Relationship Between School-Based Health Centers and the Decline in the Denver Black Teen

Fertility Rate During the 1990s" provides strong indirect evidence of the role that school-based health centers played in reducing teen fertility in Denver and in the state of Colorado among Black adolescents. This article underscores the value of school-based health and its role in impacting adolescent teen fertility. Some of the lessons learned may apply to addressing Latina teen fertility as well. The article will be published during FY 2006.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30	32	35	35	35
Annual Indicator	28	28	29.3	29.3	35.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35.5	35.5	36	36	36.5

Notes - 2002

No objectives were set for 1998 and 1999.

Notes - 2003

Data are collected every three years; data shown under the 2003 heading are the same as the data reported under the 2002 heading.

Notes - 2004

Survey data are collected every five years.

a. Last Year's Accomplishments

The 2004 target was 35.0 percent and 35.2 percent was achieved. The target was met.

This goal was met based upon the results of a survey, the Basic Screening Survey, that indicated that 35.2 percent of third grade students received sealants. However, Colorado is still below the Healthy People 2010 goal of 50.0 percent.

The survey incorporated data on more than 2,000 third grade children in 44 representative Colorado schools. An oral epidemiologist selected schools based on free and reduced lunch status. Of the 50 schools originally selected, 17 declined to participate, and of their replacements, another six declined to participate; therefore, 44 schools participated. Within the participating schools, 68 percent of third graders returned signed permission slips allowing them to be screened. The total sample size was 2,031 children. Because of the strength of the

sampling technique and degree of participation, these data have been submitted to the National Oral Health Surveillance system.

The Chopper Topper Sealant Program provided over 3,800 sealants to 1,118 second grade children in 32 qualifying schools (with over 70 percent free and reduced lunch participation). The one-year retention rates were 83 percent. This indicates a significant success in oral health outcomes because these teeth were still decay-free and had retained their sealants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identifed additional resources and other partners to expand the dental sealant project.	X	X		X
2. Began development of a Colorado surveillance system that contributes to the National Oral Health Surveillance system.			X	X
3. Tracked available oral health status and risk indicators.				X
4. Carried out the Basic Screening Survey and identified sentinel schools for next cycle.				X
5. Provided technical assistance to local advisory committee meetings interested in instituting school-based sealant programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 35.5 percent.

The Basic Screening Survey is only done once every 5 years and it will be difficult to assess change on a year-by-year basis.

The Oral Health Program has also contracted with Rocky Mountain Youth's Ronald McDonald Mobile van to provide sealants in the schools in Aurora, Commerce City, and Glendale. The Oral Health Program is also reviewing plans to expand to the Colorado Springs area. The Program is also working with Denver Health to develop a school-based sealant program for Denver County that will be functional in the 2006-2007 school year. This will allow the Chopper Topper project and Ronald McDonald van to concentrate their efforts in the surrounding metro Denver counties only. The projects may then be able to cover all eligible schools in the area, consistent with the Oral Health Program's sealant expansion plan.

c. Plan for the Coming Year

The FY 2006 target is 35.5 percent.

Through funding from the Centers for Disease Control and the State Oral Health Collaborative Systems grants, a full-time sealant coordinator/health educator will be hired. This position will assist the Oral Health Program in expanding the school-based sealant program, using the sealant expansion plan. This coordinator will work with school districts to gain participation,

identify potential dental contractors in each of the areas, assure uniform reporting guidelines, and develop relevant educational materials to explain the program.

One significant barrier to expanding the sealant program statewide, in addition to funding, is lack of support by the dental community. The Oral Health Program director is chair of the Sealant Task Force for the Association of State and Territorial Dental Directors. A survey was conducted in FY 2004 that indicated that 57 percent of states with school-based sealant programs had difficulties with the local dental community. The Oral Health Program director has been working with CDC on a "sealant expert panel" to address the barriers with the American Dental Association and the American Association of Pediatric Dentists. The panel has met twice and will be presenting preliminary findings to the National Oral Health Conference in May 2006. It is hoped that these associations will work with their members to support public health's school-based sealant efforts.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.5	3.5	3.5	3.5	3.3
Annual Indicator	4.0	4.9	5.4	4.4	4.2
Numerator	36	45	51	42	41
Denominator	909836	921233	943985	955587	966203
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3	3	2.5	2.5

Notes - 2002

No objective was set prior to 1998.

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under 2003 are from calendar 2002.

Notes - 2004

Data shown under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was a rate of 3.3 per 100,000 and rate of 4.2 per 100,000 was achieved. The target was not met.

The rate of deaths to children aged 0-14 caused by motor vehicle crashes declined to 4.2 per 100,000 in 2003 but this drop reflected no statistically significant change for the past 13 years. Forty-one children died in motor vehicle crashes in 2003. To meet the goal of 3.3 deaths per 100,000, no more than 34 children should have died, a difference of 7 fewer deaths.

In 2002, a child safety law was passed requiring 4- and 5-year-olds over 40 pounds and under 55 inches to use booster seats in order to use seatbelts safely. It went into effect in August 2003, with enforcement beginning in August 2004. It is anticipated that there will be fewer deaths, at least among this age group, as awareness of the law increases and enforcement begins to have an impact. Between 1990 and 1994, the motor vehicle fatality rate for 4- and 5-year-olds averaged 4.7, and the rate declined to 3.9 (1995-2001) after the general seatbelt law was passed. In 2003, 4 children ages 4-5 died in motor vehicle crashes for a rate of 3.2 per 100,000. We anticipate a further reduction of this rate in the future as a direct result of the booster seat law.

A three-year CDC cooperative agreement to promote booster seat use for children ages 4 to 8 in Colorado Springs through community-wide education and distribution of booster seats was completed. Evaluation of this project through pre- and post-intervention observational surveys showed an increase in booster seat use from 11 percent in 2000 to 46 percent in September 2004. Information is available on a CD (Colorado Booster Seat Project 2000-2003: A How to CD) at www.cdphe.state.co.us/pp/injuryprevention. State health staff have distributed the CD to local programs in Colorado and to other states.

In October 2003, Colorado was one of two states to receive a CDC cooperative agreement entitled "Community-Based Interventions to Reduce Motor Vehicle-Related Injuries." This four-year project targets two specific motor vehicle-related areas: 1) increased booster seat use among children ages 4-8 in child care facilities in El Paso County, and 2) enhanced seat belt enforcement in the two rural counties of Delta and Prowers.

The Injury and Suicide Prevention Program oversaw the state SAFEKIDS Coalition. In 2004, CDPHE staff created two Colorado-specific SAFEKIDS factsheets, one on childhood drowning deaths and hospitalizations and one on pedestrian injuries. These factsheets are available on the web at www.cdphe.state.co.us/pp/injuryprevention. In March 2004, a SAFEKIDS chapter was formed in Gunnison County. The pedestrian fact sheet is attached to this section.

A model goal and objective for local MCH programs on child passenger safety was developed, and a best practices document, Preventing Motor Vehicle Occupant Injuries in Children Ages 0-14, is at www.cdphe.state.co.us/ps/bestpractices/topicsubpages/MV5.pdf.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained and expanded CDPHE's website with updated safety information.				X
2. Documented and provided data on rates of motor vehicle death at the state and local levels.				X
3. Helped coordinate and expand local Safe Kids chapters to reduce childhood injury.				X
4. Created a model goal and objective ffor local MCH programs on child passenger safety.				X

5. Created a best practice document on preventing motor vehicle occupant injuries in children ages 0-14 for the CDPHE Best Practice website.				**X**
6. Worked with the Colorado Department of Transportation statewide Child Passenger Safety program to support training of more Child Passenger Safety Technicians and develop local CPS programs.			**X**	**X**
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target for is 3.0 deaths per 100,000 children.

As part of the CDC-funded community-based intervention project, in February and March 2005, 21 child care intervention centers received staff training concerning the importance of booster seats for children ages 4-8. They were provided clarification on Colorado's Booster Seat Law; a discussion on best practices; and a "tool kit." The tool kit contained educational materials including activities for children, a booster seat, an educational video, reproducible brochures, copies of the Colorado Child Passenger Safety Law (in English and Spanish), a list of local resources, and a variety of other helpful tools for staff. These intervention centers received parent education about booster seats, the booster seat law, best practices, and received free booster seats. Approximately $15,000 worth of booster seats were distributed to families at the 21 intervention centers as of March 2005.

Injury and Suicide Prevention Program staff presented the results of the 2000-2003 booster seat promotion project at various state and national conferences. They also worked with the Colorado Department of Transportation's statewide Child Passenger Safety (CPS) program, to support training of more Child Passenger Safety Technicians and develop local CPS programs.

In February 2005, the Colorado SAFEKIDS Coalition was successful in forming a SAFEKIDS chapter in Weld County.

Injury and Suicide Prevention Program staff presented the results of the 2000-2003 booster seat project, as well as provide a description of the current community-based intervention project, at the May 2005 National Injury Prevention and Control Conference held in Denver.

c. Plan for the Coming Year

The FY 2006 target for is 3.0 deaths per 100,000 children.

Injury and Suicide Prevention Program staff will continue to work on the CDC-funded community-based intervention project, using the targeted child care centers in Colorado Springs as a way to reach parents and children with the booster seat message. The seatbelt coalitions in Delta and Prowers counties will include child passenger safety messages as part of their enhanced enforcement programs.

Staff will assist at least three local health departments or county nursing services to complete grant applications to obtain child passenger safety grant funding from the Colorado Department of Transportation. Staff will also continue to work with the Colorado Department of

Transportation's statewide Child Passenger Safety program, to support training of more Child Passenger Safety Technicians and to develop local CPS programs.

A number of local public health agencies, particularly in rural areas, will emphasize the need for objectives and activities to impact this measure. Three of the organized health departments will be using MCH dollars specifically to focus on reducing motor vehicle deaths in their counties in the coming year.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85	85	87
Annual Indicator	83.9	85.2	84.3	85.5	85.3
Numerator	52150	55750	56486	58500	59116
Denominator	62142	65429	67006	68420	69304
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87	87	87	87	87

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown for 2003 are Pregnancy Risk Assessment and Monitoring Survey data for the previous year (2002).

Notes - 2004

Data shown for 2004 are from the 2003 Pregnancy Risk Assessment Monitoring Survey.

a. Last Year's Accomplishments

The FY 2004 target was 87.0 percent and 85.3 was achieved. The target was not met.

Colorado Pregnancy Risk Assessment System (PRAMS) data (calendar 2003) show 85.3 percent of women initiated breastfeeding, essentially sustaining the 2003 rate (85.5 percent). The CDC WIC Immunization Survey, which also includes breastfeeding data, reported the 2003 initiation rate as 83.1 percent, a comparable rate. The combined duration rates for all Colorado mothers at 20 weeks (PRAMS data) also expressed this decrease in breastfeeding rates: from 35 percent in 2002 to 31 percent in 2003. The CDC National Immunization Survey reported a substantially higher rate at 6 months of 45.6 percent.

Colorado compares breastfeeding rates and patterns across different years and between mothers enrolled in WIC and mothers not enrolled in WIC using a survival analysis technique for PRAMS data that yields breastfeeding continuation rates for up to 20 weeks after delivery. The data showed that the initiation rates for WIC-enrolled mothers appear to have increased from 79.6 percent in 2002 to 81.0 percent in 2003 and the initiation rates for mothers not enrolled in WIC appear to have decreased slightly from 2002 (88.2 percent) to 2003 (87.3 percent). In Colorado, births to mothers enrolled in WIC comprise one-third of all births.

Improving breastfeeding duration rates is an ongoing focus area for Colorado. CDC WIC data showed a rise from 25.7 percent (2002) to 26.9 percent (2003) in the proportion of infants being breastfed at 6 months of age. The data also show an increase of 5 percentage points over the last decade for WIC breastfeeding rates of infants at 6 months of age (21.6 percent in 1994 and 26.9 in 2003); and again at one year of age (11.3 percent in 1994 and 15.4 percent in 2003).

WIC loaned over 700 breast pumps to program participants statewide. In June 2004 WIC completed the pilot of a single-user electric breast pump issuance program. Major findings were that women who received a single-user electric breast pump (in comparison to a loaned electric breast pump) were more likely to offer breast milk exclusively and to delay, if introduced, formula.

WIC also promoted an exclusive breastfeeding campaign during World Breastfeeding Week in August 2004. The program teamed up with the Colorado Physical Activity and Nutrition Program (COPAN) and the Colorado Cancer Coalition to offer "Babies Were Born to Be Breastfed" sun hats to mothers who chose to exclusively breastfeed their newborns. The COPAN Breastfeeding Promotion Task Force also made strides with the development of a breastfeeding section in the Colorado State Plan and a Colorado Breastfeeding Promotion Resource Kit.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collected data and published a summary of hospital practices around breastfeeding.				X
2. Promoted an exclusive breastfeeding campaign during World Breastfeeding Week.				X
3. Increased issuance by WIC staff of exclusively breastfed "food packages" to infants.	X			
4. Piloted and began evaluation on a single-user electric breast pump issuance program.		X		X
5. Participated in the development of a breastfeeding section in the COPAN State Plan and a Colorado Breastfeeding Promotion Resource Kit.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 87.0 percent.

The Colorado targets are set at 87.0 percent for initiation of breastfeeding and 50.0 percent for breastfeeding at six months. The collaborative efforts of Colorado's Breastfeeding Task Force ,the WIC Program, the Colorado Physical Activity and Nutrition Program (COPAN)), and many community members and organizations are directed at developing a variety of strategies to support women who choose to breastfeed their infants.

The Breastfeeding Promotion Resource Kit was distributed statewide and used as the foundation for the state task force's strategic plan. COPAN awarded mini-grants to 10 agencies to implement activities to support breastfeeding. Activities included the purchase of pumps for two worksites; the development and material support of breastfeeding classes for clinics in metropolitan and rural areas; and the purchase of educational materials for nurses who provide home visits to new mothers. Other activities included hospital staff training and support. Research was conducted on child care centers as breastfeeding-friendly environments, and providers' attitudes and knowledge on breastfeeding surveyed. With the support of funding from the CDC through COPAN, a breastfeeding support research project for Latina women is taking place in Denver.

COPAN, with MCH support, facilitated a Certified Breastfeeding Educator training for 112 health care professionals who resided primarily in rural southeast Colorado. These professionals are trained to help women overcome breastfeeding challenges.

The WIC Program began preparation for the use of breastfeeding peer counselors in its agencies. Five agencies by mid-summer had peer counselors who could offer support to WIC participants. All WIC staff were offered breastfeeding training at the State WIC Meeting in May. In August, WIC staff will promote "Breastfeeding and Family: Loving and Healthy," as part of World Breastfeeding Week. Local WIC agencies reached out to organizations in their communities to promote this message and to share materials for the national breastfeeding campaign. All agencies have a class outline on breastfeeding, a supply of breastfeeding videos in both English and Spanish, and a breast model used in educating prenatal and postpartum women.

Several hundred single-user electric breast pumps were made available in the fall to the WIC agencies. These pumps are offered as a support to women who are separated from their infants for at least 30 hours a week. The project continues for one year, after which an evaluation will determine if it should be continued.

The COPAN Breastfeeding Promotion Task Force is continuing and expanding the Breastfeeding-Friendly Worksite recognition program. MCH funds support an in-depth analysis of statewide breastfeeding initiation and continuation rates and results are shared with Colorado communities. A report will be completed that provides information on the impact of hospital policies on breastfeeding.

c. Plan for the Coming Year

The FY 2006 target is 87.0 percent.

A variety of breastfeeding projects will continue expansion of statewide breastfeeding efforts in diverse settings. It is anticipated the combined result of these complementary activities will lead to improved breastfeeding rates.

The Colorado Breastfeeding Task Force will develop a statewide effort to promote community support networks for breastfeeding mothers. They will also provide information to hospitals on the results of the 2003 hospital survey. The breastfeeding report completed in FY 2005 will be

disseminated widely. The report will also include information that the hospitals can use to improve their efforts to be more "baby friendly."

COPAN anticipates sponsoring another lactation training opportunity, and will offer worksite grants to promote and support breastfeeding. Research, development, and promotion of a breastfeeding curriculum for medical residents and nursing education will be a major effort of the COPAN Breastfeeding Promotion Task Force.

The WIC Program will track the impact of the single-use electric breast pumps and determine if the program should be continued. Contingent on the availability of funds from USDA, the peer counselor program may be expanded to other agencies or within the existing agencies.

The findings of a research dissertation project on assessing the knowledge, behaviors, and attitudes of Colorado child care providers on breastfeeding will be used to develop interventions for child care center directors and teachers to support mothers' ability to continue breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	95	95	95
Annual Indicator	90.0	90.7	94.9	96.2	97.2
Numerator	59025	59337	63589	65839	67329
Denominator	65583	65429	67006	68465	69304
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Numbers shown under each year heading are data pertaining to the previous calendar year.

Notes - 2004

Data under the 2004 heading are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 95.0 and 97.2 was achieved. The target was exceeded.

This was the second year that Colorado exceeded the 95.0 percent level. Of 69,771 infants born (including 246 births to non-Colorado residents), a total of 67,614 were screened in 2003. The rescreening rate was 87.5 percent for those who failed the initial screening.

The Infant Hearing Program focused special attention on two groups of infants with less than optimal screening percentages. These two groups were babies born at home and Latino babies who failed two hearing screens without appropriate diagnostic follow-up. Earlier enhanced efforts directed toward babies, who for reasons of medical necessity were transferred to another hospital, have increased the number of screens and rescreens reported in that population.

The screening rate for home births almost doubled in 2004 to over 20 percent. The availability of portable hearing screening machines in the statewide regional offices of the Health Care Program for Children with Special Needs, which can be borrowed by local lay midwives, and a follow-up letter program appear to have contributed to the improved screening rates for infants born at home.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improved data integrity and engaged in detailed analysis regarding disparities found among Hispanic infants.				X
2. Used outreach methods to extended hearing screening to subpopulations with low screening rates (home births and Hispanics).		X		
3. Continued development of CHIRP data system.				X
4. Continued outreach and training efforts to lay midwives.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 revised target is 98.0 percent.

The target is 98.0 initial screening rate and an 80.0 rescreening rate, both of which are expected to be met. The increasing rate of babies born at home who receive a screen for hearing loss has continued into 2005.

Improvements in data integrity and reporting continue. An analysis of health disparities, particularly among Latino children, showed higher rates of confirmed hearing loss among Colorado Hispanics, as compared to non-Hispanic Whites. The state birth defects registry, Colorado Responds to Children with Special Needs, analyzed confirmed hearing loss data from 1996-2003, and found statistically significant differences between them. Given this discovery, additional and more extensive statistical analysis will take place. Another analysis of the newborn hearing screening database investigated factors impacting lower rescreen rates. It was discovered that the only significant predictors were maternal smoking and unmarried

status.

The 14 HCP regional offices are sending letters in English and Spanish to families of babies who have failed two hearing screenings and who have not received the requisite diagnostic assessment.. The letters explain how important it is for these children to see an audiologist and urge families to schedule diagnostic exams. In some locales, public health nurses from these regional offices make home visits to families and facilitate these arrangements.

As most of these "twice-failed" babies are Latino, and given their possibly higher genetic risk for hearing loss, this letter program is an integral part of our enhanced follow-up activities for this population, and will continue indefinitely. The ongoing partnerships and outreach efforts with community organizations serving Colorado's Latino population, including El Grupo Vida and Dia de la Mujer Latina, continue to expand.

The main state office of the Health Care Program for Children with Special Needs is also involved in the follow-up letter campaign. Letters are sent to families whose babies either were never screened before hospital discharge, or who failed the first screen. A substantial number of these letters are sent to families with babies born at home.

Project ECHO (Early Childhood Hearing Outreach) will begin in the summer of 2005 in four pilot sites. The Colorado Infant Hearing Program is collaborating with the National Center for Hearing Assessment and Management to screen infants and toddlers in Early Head Start programs. This will enable the program to identify infants who did not receive a newborn hearing screen, did not receive appropriate follow-up for failed newborn hearing screens, or who have a progressive hearing loss. Children identified at risk for persistent otitis media will receive medical interventions.

c. Plan for the Coming Year

The FY 2006 target is a 98.0 percent.

Continuing development of the Newborn Evaluation Screening and Tracking/ Clinical Health Information Records of Patients (NEST/CHIRP) database funded by a multi-year CDC Early Hearing Detection and Intervention grant should result in increased data integration, allowing for greater efficiencies and enhanced follow-up activities across multiple health programs, including the letter notification project. We plan to create and distribute culturally competent promotional materials to raise awareness among Colorado Latinos of the importance and the availability of early hearing screening and intervention.

The experience from the follow-up letter program has reinforced the importance of establishing and maintaining easy and reliable referral systems to statewide resources for screening, rescreening, and diagnostic evaluations. It is particularly important for those families without insurance and/or those families with a limited understanding of the increasingly complex health care delivery system.

Many families come into the state health department's Vital Records office in Denver to obtain certified copies of birth certificates. A Spanish language continuous loop video on newborn hearing screening and newborn metabolic screening will be played in the waiting room. This Spanish language video will be distributed to all state birth hospitals and HCP Regional Offices.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11	10	15	15	15
Annual Indicator	10.7	14.6	12.9	15.1	14.3
Numerator	114290	160700	158550	184272	176328
Denominator	1064041	1100795	1229081	1220344	1233064
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	14	13	12	11

Notes - 2002
No level set prior to 1999.

Data shown under each year's heading are for the most recent available year.

Notes - 2003
Data shown under each year's heading are for the most recent available year. Data shown under 2003 are from the American Academy of Pediatrics Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment State Reports for 2002, published October 2003.

Notes - 2004
Data shown under 2004 are from the American Academy of Pediatrics Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment State Reports for 2003, published October 2004.

a. Last Year's Accomplishments

The FY 2004 target was 15.0 percent and 14.3 was achieved. The measure was met.

Using data available from the American Academy of Pediatrics, an estimated 14.3 percent of all children in Colorado did not have health insurance in 2003. The total number of uninsured children through age 18 in Colorado is an estimated 176,328.

Colorado's rate of uninsured children is high compared to other states. Only seven states had higher rates of uninsured children in 2003. In the previous year, 2002, only three states had higher rates, so Colorado's relative ranking appears to have improved between 2002 and 2003.

For 8 months of FY 2004, Colorado's Child Health Plan Plus (CHP+) was not open for new applications between November 1, 2003 and July 1, 2004. (The 14.3 percent rate reported above does not cover exactly the same time period.) We anticipate that final data for 2004 will show a drop in coverage because of this program constraint. In November 2003 a total of 53,000 children were enrolled in CHP+; in August 2004, the number had declined to 35,000. An estimated 89,000 children were potentially eligible for the program, equal to 7.4 percent of all children. The enrollment figure of 35,000 indicates that fewer than 3.0 percent of all children were enrolled.

Beginning in January 2004, the Health Statistics Section of the state health department began collecting data for a new Child Health Survey for children ages 1-14. In future years, we anticipate using the Child Health Survey data to determine the percentage of uninsured children. However, health insurance data for 2004 were not yet available at the time this grant was submitted.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Documented and provided data at the state level for children without health insurance.				X
2. Encouraged enrollment in CHP+ through local health agencies and community coalitions when the program was not capped.				X
3. Analyzed preliminary Child Health Survey data and health insurance coverage.				X
4. Participated on committees of RWJ-funded Covering Kids and Families to improve policy on CHP+ administration.				X
5. Participated in internal planning group with the Office of Oral, Rural and Primary Care to identify current access to care issues.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 15.0 percent.

Applications for the Child Health Plan Plus were reopened on July 1, 2004, so a positive impact on the percentage of children covered after that date is expected.

However, the state Medicaid agency instituted the Colorado Benefits Management System (CBMS) on September 1, 2004. The new system was unable to keep up with the number of applications coming in and quickly became backlogged. In addition, county officials report an increased number of applications for Medicaid coverage being denied. As of the summer of 2005, there has been little real improvement in the ability of CBMS to process applications. Therefore, we anticipate an increase during FY 2005 in the percentage of children without health insurance simply because of this system change.

Other changes will impact the rate much more positively. In November 2004, voters passed Amendment 35 which increased the tax on tobacco in Colorado. Proceeds from the tobacco tax beginning January 1, 2005 will greatly increase coverage of children's health in the state, as well as increase coverage for pregnant women and parents. The impact of these changes on children's health insurance coverage for FY 2005 is unknown but could be significant.

c. Plan for the Coming Year

The FY 2006 target is 14.0 percent. It has been reduced from 15.0 percent to reflect the anticipated increase in access to insurance offered by Amendment 35.

With the passage of the tobacco tax, Colorado will be able to make strides toward providing health insurance coverage to a far larger group of children than has been possible in the past. Colorado's ranking has been one of the lowest of all 50 states in recent years.

Much work will need to take place in FY 2006 to institutionalize the changes that the tobacco tax will cover. The Colorado Covering Kids and Families Initiative, funded by the Robert Wood Johnson Foundation, will work to enroll all eligible children and adults in public insurance programs, will simplify enrollment and procedures, and will work to increase retention in the programs. Marketing efforts will be greatly expanded.

Further changes will need to be made to the Colorado Benefits Management System to incorporate the expansions in eligibility. Access to providers will be critical. An actual expansion of coverage to more children and pregnant women rests on the availability of providers who will accept Medicaid clients and payments; this may prove to be the next major hurdle to overcome.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	93	95	97	97	90
Annual Indicator	84.7	83.7	86.5	86.6	76.9
Numerator	198911	205061	230502	233467	260497
Denominator	234911	245061	266502	269467	338919
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	80	83	85	88

Notes - 2002

No objectives set prior to 1999.

Notes - 2003

Data pertain to the fiscal year, i.e., 2003 is FY 03 data. The numerators are taken from Form HCFA-416: Annual EPSDT Participation Report.

Notes - 2004

The percentage receiving a service is sharply lower than in previous years. This is because of a change in methodology for the calculation of the numerator and the denominator.

a. Last Year's Accomplishments

The 2004 target was 90.0 percent, and 76.9 was achieved. The target was not met.

There were an estimated 260,497 children between the ages of 1 and 21 (at least age 1 but under age 21) who received a paid service through the Medicaid program, according to 2004 data from the Colorado Department of Health Care Policy and Financing. There were an estimated 338,919 children age 1 or older who were potentially eligible for Medicaid.

The estimate of the numerator (260,497) was not easily done. Medicaid provides the number of children eligible for EPSDT services in the age group, but does not provide the number of children who actually received services. The Medicaid reporting document, CMS 416, shows a total of 273,919 children enrolled, but we know that a lower number actually received services. A CMS 2082 report for 2002 that included both the number of eligible children and the number of beneficiaries allowed a calculation that showed that 95.1 percent of eligible children were beneficiaries. While the CMS 2082 report data pertained to 2002, they were the latest data available and were used with the 2004 data to estimate the number of children served in 2004.

The estimate of the potentially eligible (the denominator) is more difficult to make than the estimate of the number served. We know from National Performance Measure 13 (percent of children without health insurance) that there are an estimated 176,328 children age birth through 18 in Colorado who do not have health insurance (14.3 percent of all children in the age group). Some of these children are eligible for Medicaid, others are eligible for Child Health Plan Plus, and others are not eligible for either program. In past years we have used a figure of 36,000 children as an estimate for those eligible but not covered. Using this figure, we had estimated that Medicaid covered 83 to 87 percent of potentially eligible children in the state between 1999 and 2003. However, using the American Academy of Pediatrics estimate (published in the fall of 2004) that 34.7 percent of all Colorado children who are uninsured are eligible but not enrolled in Medicaid increased this figure to some 65,000 children. This larger number is now included in the total number potentially eligible (273,919 enrolled plus 65,000 eligible unenrolled equals 338,919). As a result, the percentage served in 2004 has fallen substantially from previous estimates.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Documented and provided data for children receiving Medicaid services through IRIS (Integrated Registration and Information System).				X
2. Reviewed Medicaid information.				X
3. Worked with Colorado Health Institute in calculating the denominator for this measure.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is revised to 77.0 percent.

The target for FY 2005 has been changed, to be more realistic in light of the lower level newly estimated for 2004. How well this target may or may not be met is an open question. On September 1, 2004, the Department of Health Care Policy and Financing began using a new computer system called the Colorado Benefits Management System (CBMS). From the outset, the system was overwhelmed and many applications were denied. As of the spring of 2005, efforts continue to be made to improve the ability of CBMS to handle the Medicaid caseload.

Data are not yet available on the number of children who are being served during federal fiscal year 2005, ending September 30, 2005, but we anticipate a sharp drop. Therefore, the percentage of potentially eligible children served during 2005 is expected to be below the percentage served in 2004.

In the spring of 2005, the Office of Maternal and Child Health asked for assistance from the Colorado Health Institute in calculating the denominator for this measure. An analysis of the methods used across the country, which are described in the notes for each state posted on www.mchdata.net, revealed that few states were using comparable methods. Several states had attempted to make their own estimates using a variety of sources, including the Current Population Survey.

The Colorado Health Institute utilized the Current Population Surveys for 2002, 2003, and 2004 to calculate categorically eligible children based on family income. In addition, the Institute contacted a variety of sources to obtain data on the number of children served under the children's extensive support waiver, the home and community-based services waiver, the habilitation residential program waiver, SSI, foster care children, and pregnant women between the ages of 15 and 20. The resulting total of approximately 200,000 children who were potentially eligible or enrolled or on waiting lists, however, fell well below the number that Medicaid was serving. It is clear that more research is needed to accurately determine the number of children that are potentially eligible.

c. Plan for the Coming Year

The FY 2006 target is 80 percent.

When CBMS problems are resolved and with an improving economy, an increase in the numerator (the number of potentially eligible children served) and a decline in the denominator (the number of potentially eligible children) are anticipated. Measuring the change, however, is problematic. Technical assistance in developing an approach to accurately measuring the denominator for this performance measure will be sought from the Maternal and Child Health Bureau.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	1.3	1.2	1.2	1.2	1.2
Annual Indicator	1.2	1.3	1.3	1.3	1.3
Numerator	775	828	850	901	906
Denominator	62142	65429	67006	68420	69304
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1.2	1.1	1.1	1

Notes - 2002

Objectives not set prior to 1999.

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2003 are for calendar 2002.

Notes - 2004

Data shown under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 1.2 percent and 1.3 percent was achieved. The measure was not met.

The proportion of very low birth weight (VLBW) births in calendar 2003 remained at 1.3 percent in Colorado, the same level as in eight out of the ten most recent years. A total of 906 out of 69,304 births weighed less than 1,500 grams.

The proportion of births that are multiple births plays a role in determining the very low birth weight rate. Since the early 1990s the proportion of births that are multiple births has continued to increase, reaching a new high in 2003 of 3.4 percent. This compares to 2.3 percent in 1993. The increase in multiple births is related to the increased use of fertility drugs and assisted reproductive technologies. Multiple births are increasingly likely to be very low birth weight. Fully 30.4 percent of all multiple births were very low birth weight in 2003, while 22.3 percent were VLBW ten years previously.

The March of Dimes launched its five-year Prematurity Campaign in 2003, however, this effort does not yet appear to have had a measurable impact on this performance measure in Colorado.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Documented and provided data on very low birth weight in Colorado.				**X**
2. Collaborated with the Colorado March of Dimes in their Prematurity				

Campaign.				X
3. Monitored the impact of assisted reproductive technology on the incidence of very low birth weight.				X
4. Continued addressing ways to impact inadequate weight gain in pregnancy.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 1.2 percent.

The emphasis in Colorado continues to be on low birth weight as opposed to very low birth weight. It is possible that some of the work that focuses on reducing low birth weight will also have an impact on very low birth weight. Thus, this rate will be continually monitored, but no effort is being addressed specifically to very low birth weight reduction.

c. Plan for the Coming Year

The FY 2006 target is 1.2 percent.

Given the widespread trend toward multiple births, and the association of prematurity with multiples, we actually expect an increasing rate of very low birth weight. Our report, Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado, recommended convening a task force to discuss practice issues related to assisted reproduction (ART). However, MCH staff has reconsidered the wisdom of this approach for two reasons. First, it would be very difficult to impact medical practice in this area and second, potential recipients of ART appear unlikely to alter their use of this technology. It may be more helpful, from the standpoint of primary prevention, to instill targeted messages about optimal ages for childbearing when women are younger. Therefore, the MCH program is exploring the possibility of utilizing this message within the broader context of preconception health and planning. A CDC Preconception Summit in June 2005 provided the most recent Best Practices regarding preconception health promotion. In addition, staff plans to explore efforts initiated in other states, such as Massachusetts, related to reducing increasing rates of multiple gestation. However, most efforts will be focused on reducing low birth weight rates in Colorado as the state's rate far exceeds the HP 2010 objective.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	15	14	13.5	13	12.5
Annual Indicator	13.6	12.6	11.4	13.6	7.3
Numerator	42	39	37	46	25
Denominator	309914	309222	325922	337039	341560
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	11.5	11	10.5	10

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2003 are for calendar 2002.

Notes - 2004

Data shown under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 12.5 deaths per 100,000 teens and a rate of 7.3 deaths per 100,000 teens was achieved. The target was met.

Unfortunately, preliminary data for calendar year 2004 show an increase to 47 suicides among Colorado teens age 15-19, which will result in an increased rate for the next year.

The Office of Suicide Prevention coordinated a number of programs during the fiscal year. A youth-focused public awareness campaign utilizing radio and television public service announcements developed by the American Foundation of Suicide Prevention was aired from June 2003 through the rest of the year in Eagle, Jefferson, and La Plata Counties, and in Mesa and the San Luis Valley. The Office provided more than 21,300 public awareness materials regarding suicide prevention and Colorado's suicide prevention efforts across the state. The Office coordinated suicide prevention and intervention skills training to community members statewide. A number of trainings were offered: three "training for trainers" in Applied Suicide Intervention Skills Training (5 people trained); the Yellow Ribbon school-based suicide prevention program (56 trained); and the SAFE: TEEN school-based suicide prevention program (17 trained).

The Office co-hosted with the Suicide Prevention Coalition of Colorado the second annual statewide Suicide Prevention Summit and a fundraiser. Grants were provided to 14 local agencies for suicide prevention and education services. Local grantees used funds for a variety of youth-focused activities including increasing community awareness of suicide prevention resources through presentations to community groups, trainings, and newspaper articles; developing teen survivor support groups; funding for a local teen hotline; community coalition development; facilitation of a depression/bipolar support group; on-air youth programming of suicide prevention broadcasts; and short-term clinical therapy for suicidal teens.

The Office provided financial support to the 1-800-SUICIDE crisis line, which responded to 3,208 calls from Coloradans. Ninety-five percent of the calls were from adults and only 5

percent were from teens.

Beginning in January 2004, the Injury Epidemiology Program in the Injury Section of the Prevention Services Division has participated in the Centers for Disease Control and Prevention's National Violent Death Reporting System by gathering enhanced surveillance data on all violent deaths including suicides. Based on the information gathered on 42 teen deaths, most victims were male (83%), white (71%), died by either firearm (48%) or hanging (38%), and died at home (55%). Where documentation was available, most exhibited symptoms consistent with a mental health concern like depression.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Documented and provided data on teen suicide in Colorado.				X
2. Continued to provide training, education, outreach and support across Colorado through the Office of Suicide Prevention.				X
3. Worked on increasing availability of mental health services in schools especially those with school-based health centers.				X
4. Participated in the National Violent Death Reporting System with the goal of developing interventions to reduce suicide.				X
5. Engaged in a youth-focused public awareness campaign using radio and television public service announcements.				X
6. Co-hosted the second annual statewide Suicide Prevention Summit and the fundraiser.				X
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 12.0 deaths per 100,000 teens.

The Office of Suicide Prevention continues to coordinate efforts to reduce the number of suicides among teens by:

Providing grants to support local community-based organizations and coalitions that are currently engaged in suicide prevention activities;

Distribution of suicide awareness literature;

Providing a training of trainers program for both SAFE:TEEN and the Yellow Ribbon Suicide Prevention program, both school-based suicide prevention programs;

Co-sponsoring the annual Suicide Prevention Summit and Prisms of the Heart Suicide Prevention Fundraiser with the Suicide Prevention Coalition of Colorado;

Coordinating/collaborating with the Colorado Trust Suicide Prevention Initiative in the 10 communities receiving suicide prevention funds;

Partnering with the Child, Adolescent, and School Health Section to develop and disseminate a suicide prevention model goal and objective for local communities, incorporating evidence-based strategies that can be adopted or modified at the local level;

Partnering with the Child and Adolescent School Health Section and local community-based experts to implement a grant from the Centers for Disease Control and Prevention on Enhancing State Capacity to Address Child and Adolescent Health through Violence Prevention; and

Being a National Violent Death Reporting System site for the Centers for Disease Control and Prevention.

The Injury Epidemiology Program continues to gather information on all youth suicides in participating Colorado counties.

c. Plan for the Coming Year

The FY 2006 target is 11.5 deaths per 100,000 teens.

The Office of Suicide Prevention will continue to implement many of the initiatives referenced above that are outlined in its Suicide Prevention Plan available on the web at www.cdphe.state.co.us/pp/suicide/suicide.pdf. Activities will include continuing to coordinate statewide efforts such as a public awareness campaign directed to teens; training of community gatekeepers; and development of community based coalitions focused on suicide prevention. State funding of $210,000 is allocated for suicide prevention programs for state FY 2006, which will begin July 1, 2005.

Counties with high teen suicide rates will be encouraged to use the strategies outlined in the suicide prevention model goal and objective for local communities developed with the Child, Adolescent, and School Health Section in their MCH grant applications. The Office will continue to benefit from the enhanced surveillance data from the National Violent Death Reporting System and from community expertise convened for the Enhancing State Capacity to Address Child and Adolescent Health through Violence Prevention grant.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	62	75	75	75	75
Annual Indicator	71.6	74.8	73.8	74.6	73.5
Numerator	551	619	627	672	666
Denominator	770	828	850	901	906
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	80	83	85	87

Notes - 2002

Objectives not set prior to 1999.

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under the year heading are from vital statistics data for the previous calendar year. For esample, data shown for 2003 are for calendar 2002.

Notes - 2004

Data shown under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 75.0 percent and 73.5 was achieved. The target was not met.

A total of 666 out of 906 very low birth weight (less than 1,500 grams) infants were delivered at Level III facilities during calendar 2002.

Colorado has eight Level III facilities. Seven are located in the immediate Denver metropolitan area: Porter, Rose, St. Joseph's, Presbyterian/St. Luke's, Denver Health, Swedish, and University. The other Level III hospital, Memorial, is located in Colorado Springs.

During the spring of 2004 the Colorado Perinatal Care Council informed its member hospitals of the results of a continuing study done by the MCH program. An earlier analysis of 1997-1999 data for Colorado showed an increased risk of mortality among very low birth weight infants born in Level I and Level II facilities, compared to infants born in Level III facilities. A repeat analysis using 2000-2002 data obtained virtually the same results: a 38 percent increased risk of mortality. Furthermore, the study revealed that among Front Range residents, 40 percent of very low birth weight births occurring in Level II hospitals took place in facilities that were within 5 miles of a Level III hospital. Indeed, two out of three very low birth weight births occurring in Level II hospitals took place in facilities within 10 miles of a Level III hospital. The study also showed that the vast majority of very low birth weight births born outside Level III hospitals were born to residents along the Front Range. The problem of geographic distance from Level III hospitals was not the reason for the relatively low percentage of very low birth weight infants born in Level III hospitals.

In the summer of 2004 the Colorado Perinatal Care Council began to prepare new recommendations concerning the conditions under which deliveries to infants likely to be very low birth weight should occur at Level III facilities. However, the Council was aware that the American Academy of Pediatrics was planning to release new guidelines around levels of perinatal care in the fall of 2004. At the end of 2004, the Council elected to postpone any revisions in its recommendations until after the release of the new guidelines.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provided data to the Colorado Perinatal Care Council showing improved outcomes for Level III deliveries.				X
2. Supported development and dissemination of Colorado Perinatal Care Council position statement on maternal transfer for gestations under 32 weeks.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 75.0 percent.

In November 2004, the American Academy of Pediatrics (AAP) released its new guidelines, "Levels of Neonatal Care." In the guidelines, recommendations are made for uniform nationally applicable definitions of levels of neonatal intensive care that are based on the capability of facilities to provide an increasing complexity of quality of care. In particular, distinctions are more finely drawn between Level II specialty care and Level III subspecialty care than in the old system. Level II facilities are divided into two sublevels: IIA and IIB; care can be provided to infants born at greater than 32 weeks gestation and weighing at least 1500 grams in IIA facilities, while IIB facilities can provide mechanical ventilation for brief durations in addition to the care provided in IIAs. Level IIIs are divided into three sublevels: IIIAs can provide comprehensive care for infants born at more than 28 weeks gestation and weighing more than 1000 grams, while IIIBs can provide care to infants at 28 weeks gestation or less and under 1000 grams. The distinctions between Level IIB and Level IIIA are especially important in terms of providing care to very low birth weight infants under this performance measure.

Between January and March 2005 the Colorado Perinatal Care Council hosted a series of Town Hall meetings across the state to discuss the new guidelines. Meetings in Denver, Boulder, Grand Junction, and Colorado Springs were well attended and the guidelines were discussed at length. The Council then proposed that hospitals would continue to use a voluntary self-assessment tool to designate their level of care, and that the new tool would reflect the new recommendations. Self-designations, utilizing the new AAP criteria, are expected to be completed by the end of calendar 2005.

c. Plan for the Coming Year

The FY 2006 target is 80.0 percent.

At this time it is not possible to predict whether some hospitals that are currently classified as Level IIs will attain a IIIA status. In addition, it is unknown whether some Level II hospitals that currently care for infants below 1500 grams will begin to refer those cases prior to delivery to Level IIIs.

Colorado's current practice patterns show that fewer than three out of every four very low birth weight infants are born in Level III facilities. The Healthy People 2010 goal is for 90.0 percent of these infants to be born in at least Level IIIA facilities. Colorado may be able to achieve the state target of 80.0 percent with only some change in the current distribution of births, but it will

be unable to approach the Healthy People 2010 goal without a determined effort to really change practice patterns. It is possible that this will begin to occur as a result of adoption of the new recommendations, but at the time this grant was submitted in the summer of 2005, the potential impact remains unknown.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	83	83	84	85	85
Annual Indicator	81.7	80.7	79.8	79.1	79.3
Numerator	50373	52064	52586	53293	54117
Denominator	61688	64477	65928	67414	68255
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	83	84	84	85

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2003 are for calendar 2002.

Notes - 2004

Data shown under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 85.0 percent and 79.3 percent was achieved. The target was not met.

The year 2003 marks the sixth time that Colorado's level was lower than the U.S. level. Colorado continues to rank in the bottom tier of all states on this indicator, along with nine other states that have fewer women beginning first trimester care than Colorado.

Two factors contributed toward the overall prenatal care rate. The proportion of women needing care who were Hispanic, especially the proportion of women who themselves were born in Mexico, continued to grow. Since these women were less likely to begin care early because of financial barriers and problems gaining access to care, the overall rate was impacted because they contributed an increasing number of births. In 2003 a total of 11,362 births, one out of every 6 Colorado births, was to a foreign-born white Hispanic woman. In 1990, the number had

been 2,034, comprising just one out of every 26 Colorado births.

The second factor is that the proportion of women obtaining early prenatal care has declined for each racial/ethnic group. For white Hispanic women, the 1997 proportion (the best year for all groups) was 69.6 while the 2003 proportion was 67.0. For black women, the proportions were 77.3 and 70.9 respectively. For white non-Hispanic women, the proportion was 87.9 in 1997 and 86.1 in 2003. However, each of the rates for 2003 was slightly higher (better) than for 2002.

An analysis at the county level reveals that only 9 counties out of 64 (one in seven) attained the 85.0 percent target in 2003. In 1997 a total of 23 counties had attained the 85.0 percent level, and in 2002 a total of 16 counties had attained this level. The number of counties meeting the target appears to be decreasing rapidly.

Lastly, the sheer volume of births to women who cannot obtain insurance coverage because they are undocumented contributes a great deal to Colorado's low first trimester care coverage rate. Data enumerating the number of women who are in this group is not available.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Documented and provided data on a state and local level.				X
2. Continued efforts to promote insurance coverage for undocumented women and other low-income women.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On July 1, 2004, Governor Owens lifted the freeze on the Child Health Plan Plus program, which had limited the number of women who could obtain prenatal care since November 2003. However, on September 1, 2004, the Colorado Department of Health Care Policy and Financing terminated the Presumptive Eligibility provision that allowed pregnant women to receive Medicaid coverage while their applications for coverage were being processed, a practice that required between 45 days and 3 months. At the same time, the Colorado Benefits Management System (CBMS), an automated, rules-based eligibility determination system, was initiated in September 2004. Systems issues in the following months created significant application backlogs which resulted in delays in determining eligibility.

At the end of 2004, the Office of MCH began to monitor birth certificate data regarding prenatal care initiation very closely. Information was analyzed on first trimester care and adequacy of care for each month's deliveries through May 2005, when this grant was prepared. While there was little change in the proportion receiving first trimester care among women delivering in

early 2005 compared to early 2004, there was a 13 percent increase in the proportion of women with care categorized as inadequate among high-risk women delivering in April and May 2005 compared to high-risk women delivering in April and May 2004. (High-risk women were defined as unmarried, under 25 years of age, and without a high school education). April 2005 was clearly the month when the full impact of the termination of presumptive eligibility in September 2004, seven months previously, was seen in birth certificate data collected at delivery. These data suggest that the termination of presumptive eligibility so far has had more of an impact on the number and timing of visits than it has had on the initiation of early care.

State staff has also been monitoring the experience of local contractors as they try to assure access to prenatal care in light of changes in Medicaid rules and procedures. The majority of local health entities are now completing Medicaid applications for pregnant women and batching them to the central Medicaid office, which is attempting to determine eligibility more quickly. However, local sites have noted a decrease in the number of pregnant women coming into local agencies since presumptive eligibility was eliminated. State staff conducted an outreach survey of local sites to determine which outreach practices seem to be most effective in bringing pregnant women in for services. An audio conference on prenatal outreach was held in April 2005 to highlight Best Practices. Furthermore, a Learning Community has been developed to focus on first trimester care in order to improve performance with first trimester enrollment. The Learning Community first met in March 2004 and continues to meet monthly during FY 2005.

c. Plan for the Coming Year

The target for FY 2006 continues to be 85.0 percent. The Healthy People 2010 goal is 90.0 percent, and many states are making steady progress toward this goal. In 2003, 21 states had rates of 85.0 percent or greater, and four had already met the 2010 goal.

In the MCH needs assessment for 2005, analysis of Colorado Behavioral Risk Factor Surveillance System data for young women age 18-24 revealed that more than one-quarter (27.3 percent) had no health insurance in 2002, a rate slightly higher than several years earlier. However, during this same year, an increasing percentage of women ages 25-34 reported having no insurance, a rate of 25.1 percent in 2002, a large increase from the 1999 rate of 17.1 percent.

It appears that Colorado has been unable to improve the percentage of women receiving first trimester care in recent years because of declining rates of both general and prenatal health insurance coverage for young women, a lack of insurance coverage for pregnant undocumented women who contribute a large number of births in the state, and recent changes in Medicaid rules (elimination of presumptive eligibility) and procedures (CBMS) for the even larger group of women whose prenatal care is covered by Medicaid. We have elected to monitor this measure until attempts can be made to increase financial access to prenatal care, especially for undocumented women. We are requesting technical assistance to help us develop creative ways to address the problem.

Plans are to continue monitoring first trimester enrollment on a monthly basis until presumptive eligibility is re-instituted and/or CBMS is determining eligibility as originally intended. The Learning Community on first trimester enrollment will continue to meet.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The proportion of high school students reporting having drunk alcohol in the past month.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40		50	50	49
Annual Indicator		50.9	50.9	48.4	48.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	47	46	45	44

Notes - 2002
There was no target set for FY 01.

Data shown under each year's heading are for the most recent available year.

Notes - 2003
Data shown under the year heading 2003 are from the 2003 Youth Risk Behavior Suvey. No data are available under the year heading 2002.

Notes - 2004
The data reported for 2004 are the same YRBS data shown in 2003. No update is available.

a. Last Year's Accomplishments

The target for 2004 was 49.0 percent and 48.4 percent was achieved. The target was met.

According to the 2003 Colorado Youth Risk Behavior Survey, 48.4 percent of students reported alcohol use. While the results are not representative of all high school students because of sample size, they are consistent with data reported in 2001 (50.9 percent), and are used here as the best available data.

The Child, Adolescent, and School Health Section partnered extensively with the Colorado Department of Human Services Alcohol and Drug Abuse Division (ADAD) to address youth alcohol, tobacco, and other drug use. ADAD develops, implements, and evaluates prevention programs on a statewide basis to reduce the health, social, and economic consequences of alcohol, tobacco, and other drug abuse.

ADAD funded 47 local programs using Substance Abuse/Mental Health Service Administration and state monies. The Substance Abuse Prevention Block grantees are encouraged to impact multiple levels of the social structure, including individuals, families, groups, institutions, and communities of all major ethnic and cultural groups.

ADAD also funds the Rocky Mountain Center for Health Promotion and Education to manage the Regional Prevention Center (RPC). The RPC offers training and technical assistance that is responsive to cultural differences and the varying practical needs of communities throughout

Colorado. Technical assistance and capacity-building efforts target underserved or unserved populations, and address regional prevention needs.

The state health department has collaborated with ADAD to develop a Best Practices Web page for alcohol use prevention. The Web page synthesizes prevention and intervention strategies and programs and interventions that are known to work for alcohol use prevention. The Best Practices Web site, which has over 40 health topics, provides a centralized resource of programs and strategies that work for program planners and professionals working in prevention; grantees; and local health departments. The address for the Best Practices Web site is www.colorado.gov/bestpractices/alcoholabuse/index.html.

School-based health centers (SBHCs) are another major component of our strategy to reduce alcohol use. SBHCs place a strong emphasis on preventing and reducing substance abuse among adolescents. Primary care providers in secondary schools utilize the Guidelines for Adolescent Preventive Services (GAPS) to identify and counsel students who are using drugs and alcohol. Drug and alcohol counselors available on-site deliver prevention curricula, and carry out assessment, intervention, and treatment of identified students.

The strongest school-based models offer students in-school intervention and psychoeducational programs as an alternative to suspension from school for substance abuse infractions. School-based programs are widely considered to be the best approach for early identification and intervention with substance abuse behaviors.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluated data on substance abuse from the most recent Youth Risk Behavior Survey.				X
2. Collaborated with the Regional Prevention Center to develop strategies to reduce alcohol use.				X
3. Collaborated with the Alcohol and Drug Abuse Division at the Colorado Department of Human Services.		X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for 2005 is 48.0 percent.

The Alcohol and Drug Abuse Division of the Colorado Department of Human Services continues to implement many of the initiatives referenced above. The Substance Abuse Prevention Block grantees are encouraged to impact multiple levels of the social structure, including individuals, families, groups, institutions, and communities of all major ethnic and cultural groups.

Colorado has received a $2,350,965 grant to advance community-based programs for substance abuse prevention, mental health promotion, and mental illness prevention. Colorado is one of 21 states to receive this funding from the Substance Abuse and Mental Health Services Administration for a five-year Strategic Prevention Framework State Incentive Grant. The program, which is housed in the Alcohol and Drug Abuse Division at the Colorado Department of Human Services, is a collaborative effort between ADAD and the Prevention Leadership Council. The funding is to be used to implement a five-step process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors. The five steps are: (1) conduct needs assessments; (2) build state and local capacity; (3) develop a comprehensive strategic plan; (4) implement evidence-based prevention policies, programs, and practices; and (5) monitor and evaluate program effectiveness, sustaining what has worked well. The Director of the Adolescent Health Program serves on the Strategic Prevention Framework State Incentive Grant Advisory Committee and its Underage Drinking Workgroup

The Tony Grampsas Youth Services Program received $3.4 million in state Tobacco Master Settlement funds to support its 105 programs during state fiscal year 2005 as well, and a new Program Director was hired.

c. Plan for the Coming Year

This performance measure will not be continued. However, this area will be addressed by a new measure that reports on the proportion of high school students reporting binge drinking.

State Performance Measure 2: *The proportion of all pregnancies that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	48	37	37	37	36
Annual Indicator	38.4	39.8	39.8	38.9	41.0
Numerator	33183	26040	26670	26600	28414
Denominator	86465	65429	67006	68420	69304
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	36	35	35	35	35

Notes - 2002

Data for 2002 are estimated, based on PRAMS data for 2001.

Notes - 2003

Data shown for 2003 are from the 2002 PRAMS survey.

Notes - 2004

Data shown for 2004 are from the 2003 Pregnancy Risk Assessment Monitoring Survey.

a. Last Year's Accomplishments

The FY 2004 target was 36.0 percent and 41.0 percent was the measured level for the year. This target has not been met.

Unintended describes pregnancies that a woman characterizes as either unwanted (pregnancy not wanted at any time, now or in the future) or mistimed (pregnancy not wanted until some time in the future) at the time of conception. The Pregnancy Risk Assessment Monitoring System (PRAMS) data for calendar 2003 show that 41.0 percent of all births were unintended, exceeding the target level by 5 percentage points. PRAMS data for the previous calendar year (2002) showed a 39.8 percent level; the new 2003 data suggest an increase, although the confidence intervals for the survey data do not indicate a statistically significant change.

It should be noted that while the performance measure pertains to pregnancies, the actual percentages cited refer only to live births. Insofar as a number of unintended pregnancies are not carried to term, this percentage of unintended births is an underestimate of the actual number of unintended pregnancies.

County-level information on unintended births is available on the state health department's Colorado Health Information Dataset website at www.cdphe.state.co.us/cohid. Users can query the PRAMS dataset for six years of surveys (1997-2002) to obtain county-level data on pregnancy intention and a variety of birth outcomes like prematurity and birth weight. In addition, pregnancy intention data is available according to parity and use of WIC. These data are very useful at the county level to describe levels of unintended pregnancy.

PRAMS data for 2003 indicate that no real change has occurred in the state in the percentage of unintended births since data were first collected in 1997. The percentage unintended during this period has varied between 37.9 and 41.0.

Reducing the proportion of births that are unintended is dependent on many factors, one of which is access to effective contraception. A waiver to provide family planning services to low-income women was first submitted to the Centers for Medicare and Medicaid Services (CMS) by the Colorado Department of Health Care Policy and Financing in 2000. The state health department MCH staff and Women's Health Section provided assistance in writing the original waiver and responding to questions sent back by CMS over many months. A final version of the waiver proposal was submitted to CMS in February 2004, but another round of questions from CMS received in April 2004 prompted the Department of Health Care Policy and Financing to discontinue Colorado's application. A number of other states have used waivers in recent years to greatly increase the number of low-income women receiving subsidized family planning and to reduce unintended pregnancy rates.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted the Parent Power curriculum from the National Campaign to Prevent Teen Pregnancy to encourage parent-child communication about sexuality.		X		

2. Continued to work with Title X funded family planning projects on service delivery.				X
3. Targeted local population-based approaches to reducing unintended pregnancy.			X	X
4. Documented and made presentations about the problem of unintended pregnancy.				X
5. Analyzed recent declines in teen fertility and the level of unintended teen pregnancy.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 36.0 percent.

The Women's Health Section has continued to sponsor trainings on contraceptive methods to health care providers and social service and faith-based human services staff. These trainings are designed to support replication in other areas of the state of the unintended pregnancy project at the Boulder County Health Department, and to use the Parent Power curriculum from the National Campaign to Prevent Teen Pregnancy to encourage parent-child communication about sexuality. In addition, the Women's Health Section continues to administer the Title X family planning program, which serves 51,000 low-income adolescents, women, and men each year.

The Latina Teen Fertility Project is another area where the Women's Health Section is researching the best approaches to use when addressing births among young women, which are especially high in this subpopulation. An in-depth study of attitudes ascertained through focus groups has been continued this fiscal year, and a report will be submitted by September 30, 2005.

c. Plan for the Coming Year

This performance measure has been discontinued. The rate of unintended pregnancy will continue to be tracked. The state will continue to fund family planning services and contraceptive fundamentals training.

State Performance Measure 3: *The incidence of maltreatment of children younger than 18 (including physical abuse, sexual abuse, emotional abuse, and/or neglect).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25.2	25.2	25.2	5.5	7.4

Annual Indicator	6.4	5.2	6.6	7.4	9.0
Numerator	6989	5766	7532	8633	10542
Denominator	1086866	1106001	1135148	1159066	1171999
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.4	7	7	6.7	6.7

Notes - 2003

Data shown for 2003 are calendar 2003 data from the Colorado Central Registry. These are substantiated individual cases of maltreatment. The rate appears to be higher than previous years in part because each child, rather than each case, is counted.

Notes - 2004

Data shown for 2004 are Federal FY 2004 (10/1/03-9/30/04) data from the Colorado Central Registry. These are substantiated individual cases of maltreatment.

a. Last Year's Accomplishments

The 2004 target was 7.4 confirmed incidents of abuse or neglect per 1,000 children, and the rate of 9.0 was achieved. The measure was not met.

The Child Welfare Section of the Colorado Department of Human Services reported a substantial increase in the number of victims of abuse between 2003 and 2004.

Colorado has developed several programs that address the root causes of child abuse and neglect. The Colorado Children's Trust Fund is focused on parent education for both the at-large population and those identified as at-risk to perpetrate abuse. The Colorado Children's Trust Fund has continued a partnership with the Kempe Children's Foundation, a national organization focused on the prevention of child abuse and neglect. Together they conducted a social marketing campaign designed to encourage people to take action to prevent child abuse.

Another program, the Nurse Home Visitor Program / Nurse Family Partnership, funded by Colorado's Tobacco Master Settlement, targets low-income women who are expecting their first child. Enrolled women are provided with ongoing frequent case management services until the child's second birthday. This model program has demonstrated success with reducing child abuse and neglect.

During FY 2004, there were 17 Nurse-Family Partnership sites across the state, serving 49 of Colorado's 64 counties. A total of 1,637 families were served in state fiscal year 2004. One-third (34.6 percent) of participants divulged a history of physical and/or emotional abuse at their initial intake to the program. These women are clearly at increased risk for perpetrating child abuse and neglect, and the program is expected to have a very positive impact on how they treat their children.

During FY 2004 the Nurse Home Visitor providers began billing Medicaid for targeted case management services provided to Medicaid-eligible mothers. The combination of Tobacco Master Settlement funds and Medicaid revenue has allowed the Nurse Home Visitor Program to serve more mothers and families statewide.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained programs that addressed maltreatment of children e.g. Nurse Family Partnership and Colorado Children's Trust Fund.		X	X	X
2. Evaluated the effectiveness of programs considering the numbers of families served and the intensity of services.				X
3. Coordinated with Colorado Department of Human Services to improve and increase data about child maltreatment.				X
4. Partnered with evidence-based programs to increase training opportunities for local child abuse prevention programs.		X	X	X
5. Increased awareness of issues and best practices for local health and community groups by teleconference.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 7.4 substantiated cases of child abuse or neglect per 1,000 children in Colorado.

This target is the same as the one chosen for 2004. This rate measures actual number of individuals per 1,000 who were substantiated victims of child abuse or neglect in 2004, rather than incidents of abuse, which could include more than one child.

The Colorado Children's Trust Fund has resumed its granting relationship with community partners to prevent child abuse. Funding to local communities had been discontinued due to a decrease in state funds available to the program. Consequently, the Trust Fund was able to fund local agencies to assess their communities to implement the Nurturing Parenting Program, a research-proven model to prevent child abuse. Nineteen statewide agencies applied for and received these grants, which ranged from $5,000 to $10,000.

The Nurse Home Visitor Program now has served 1,962 families across the state.

c. Plan for the Coming Year

This performance measure has been discontinued. However, the Child, Adolescent, and School Health Section will continue activities to reduce the child abuse rate in Colorado, including providing training and funding for implementation of the Nurturing Parenting Program in 16 communities. The Nurse Home Visitor program will serve more families in FY 2006 as it continues to grow.

State Performance Measure 6: *The proportion of high school students reporting regular use of tobacco products.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11.0	11.0	34.4	30.9	29.3
Annual Indicator		34.4	34.4	34.4	24.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18.5	17	16	15	14

Notes - 2002

Data for 2002 are estimated using the Fall 2001 Youth Tobacco Survey data.

Notes - 2003

Data were not available from the Youth Tobacco Survey in 2003 at the time of submission.

Notes - 2004

Data under 2004 are unweighted data from the 2003 Youth Tobacco Survey.

a. Last Year's Accomplishments

The FY 2004 goal was 29.3 percent and 24.1 percent was achieved. The measure was met and exceeded.

The State Tobacco Education and Prevention Partnership (STEPP) Program received an unexpected 75 percent reduction in program funds during FY 2004. Many essential program components were downsized or eliminated.

Nonetheless, STEPP's efforts have contributed to a decline in tobacco use, which is reflected in cigarette sales data. Consumption of cigarettes per capita in Colorado continues to decline at a rate nearly twice that of the national rate. The national decline in cigarette consumption between 2000 and 2003 was 7.5 percent, while the decrease in Colorado was 13.7 percent during the same period.

The Not on Tobacco program, developed by the American Lung Association, is a school-based, 10-session youth cessation program. The program is one of only two evidenced-based youth cessation programs available in the nation. Funding for schools to implement Not on Tobacco was available through one of two state contractors: the American Lung Association as a "stand-alone" program, and the K-12 initiative led by the Rocky Mountain Center for Health Promotion and Education. A total of 820 students from 53 schools participated in the program during FY 2004. Thirty-four percent of participants quit smoking and an additional 48 percent reduced their tobacco consumption.

Forty-four Get R!EAL (Resist! Expose Advertising Lies) youth coalitions throughout Colorado participated in the Get R!EAL movement. More than 450 youth took part in youth-led advocacy activities that promoted efforts to reduce youth initiation and consumption of tobacco. In the fall of 2003, 20 Get R!EAL youth coalitions around the state conducted local cigarette butt pick-up

events. These events promoted the Get R!EAL message and exposed the marketing strategies of the tobacco industry. In spring 2004, 32 Get R!EAL youth coalitions across the state conducted smoke-free demonstrations in their local communities. The objective of these demonstrations was to bring attention to the health risks associated with exposure to secondhand smoke and to denormalize the use of tobacco.

Several training opportunities and activities were provided across the state for local coalition members. Get R!EAL coordinated a two-day Leadership Board meeting for key youth leaders who serve on one of the four statewide committees.. Additionally, Get R!EAL sponsored four regional summits around the state and trained 350 youth leaders and 90 adult sponsors on how to analyze tobacco industry manipulation, implement counter-marketing strategies, promote smoke-free environments, and advocate for policy change. Get R!EAL hosted a weekend-long strategic planning meeting for 15 youth leaders. A total of 158 schools in 23 school districts and 16 college campuses conducted activities to prevent initiation of tobacco use.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided leadership for youth-driven tobacco prevention through the Youth Partnership for Health.			X	
2. Continued the development and support of youth oriented programs through the State Tobacco Education and Prevention Program.				X
3. Monitored and reported data through the Youth Risk Behavior Survey and the Youth Tobacco Survey.				X
4. Sponsored training opportunities and activities for local tobacco coalition members.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 goal is 18.5 percent.

Newly available STEPP data has led to the revision of future annual performance objectives from those previously submitted in the block grant. STEPP relies on research from CDC and the National Task Force on Community Preventive Services. Programs funded by STEPP use evidence-based strategies that include youth empowerment and advocacy, comprehensive school-based programs, prohibition of access to tobacco products by minors, and mass media education.

The FY 2004-05 spending authority is $4,296,221, approximately one-sixth of the CDC-recommended funding level to implement Best Practices. STEPP continues to work with currently funded programs to sustain their infrastructure and efforts, and to increase their outreach.

Colorado focuses its tobacco control efforts on the principles of Best Practices. The Youth

Programs Unit of STEPP currently funds four program areas to address youth smoking prevention and cessation. These areas are addressed through community-based, school-based, and college-based activities and youth empowerment activities. Joint efforts to address tobacco prevention are coordinated with the Department of Education.

During the November 2004 elections, Colorado's voters approved an increase in the cigarette excise tax, with a portion of the new revenues going toward tobacco education, cessation, and prevention efforts.

c. Plan for the Coming Year

The FY 2006 goal is 17.0 percent.

Due to the increase in funding available from the Colorado's cigarette excise tax, STEPP expects currently funded activities to increase and to continue contributing to progress toward meeting our objectives.

Funding to statewide, youth-focused contractors including the American Lung Association (Not-On-Tobacco Program), the Rocky Mountain Center for Health Promotion and Education (K-12 Initiative), and Get R!eal should approach prior funding levels, allowing an expansion in scope and reach from the current activities. Since the majority of funding for tobacco education and prevention must now be used for youth programs, new grantees will also be funded, including community agencies that can apply for Tony Grampsas Youth Services dollars. Colorado is now one of the few states at CDC's minimum recommended funding level for a comprehensive tobacco program.

State Performance Measure 7: *The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.9	5.1	8.0	8.25	9.5
Annual Indicator	7.8	7.9	7.9	7.9	11.0
Numerator	55196	57396	58899	59438	83668
Denominator	708109	724148	742145	751049	757668
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11.5	12	12.5	13	13.5

Notes - 2003

The school enrollment data shown under 2003 are from official October 1, 2002 counts from the Colorado Department of Education.

Notes - 2004

Data shown under 2004 are from the fall of 2003.

a. Last Year's Accomplishments

The FY 2004 target is 9.5 percent and 11.0 percent was achieved. The target was met.

School-based health centers (SBHCs) are located in 10 of Colorado's 64 counties. During the 2003-2004 school year, there were 35 SBHCs serving 112 public schools, making services available to 83,668 children and adolescents. Based upon total state enrollment of 757,668 public school students, 11.0 percent of all students had access to preventive and primary, physical, and behavioral health services through the centers. The data used and the SBHC status of a school are from the October 1, 2003 official school counts.

During the 2003-04 school year, Colorado's SBHCs provided preventive, primary, physical, and behavioral health services to a total of 25,036 unduplicated student users, generating 71,854 student visits. Of these, 18,305 (25.4 percent) were for mental health and substance abuse counseling, and 1,834 (almost 3 percent) were for dental services.

The 2004 target was exceeded due to a change in how the "schools served" were counted. Previously, only students attending schools with SBHCs on-site were counted in calculating the proportion. Last year, to better reflect the reach of these programs, project staff began to track the numbers of students attending schools with a linkage to schools that offer preventive and primary care services, in addition to students attending schools in which the actual services are located.

In the fall of 2003, a three-year request for proposals was issued inviting schools and communities to submit for up to $15,000 in planning funds from MCH. Six applications were received and five were funded. Six new SBHCs were funded that included two school districts that had not had SBHCs previously. Through a technical assistance contract with the Colorado Association for School-Based Health Care, teams from the selected communities were trained to conduct needs assessments, engage communities, work with district officials, and develop staffing and services plans in preparation for opening new SBHCs.

In February 2003, a five-year grant from the CDC's Division of Adolescent and School Health was awarded to the state education department to develop state infrastructure to support local school districts in enhancing their school health programming. Funds from this grant support a lead person at the state health department to engage programs that address the school-age population. This initiative addresses obesity, tobacco use, sun safety, and improving HIV, STD, and teen pregnancy prevention education in schools.

A team of 25 state staff from the state education and health departments, representing almost 40 state-level programs directed at school-aged children, formed the Interagency School Health Team. This group was charged with coordinating and streamlining state systems and processes to support Colorado's public schools. A process for completion of a state plan and kick-off of a statewide coalition was completed.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported local school districts to plan school-based health centers in				

their communities.		X		
2. Addressed sustainability of school-based health centers beyond Maternal and Child Health funding.			X	X
3. Documented and provided data on school-based health centers for children in Colorado.				X
4. Addressed obesity, tobacco, and STDs through the CDC-funded Coordinated School Health Infrastructure grant.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The revised target FY 2005 is 11.5 percent.

Further increases are expected in the proportion of public school students impacted by school-based health centers. Five new SBHCs opened during school year 2004-05: Weld School District 6 opened programs in two elementary schools; Denver opened one middle school; and Summit School District opened a full-service SBHC at their middle school and a part-time center in an elementary school. Harrison School District 2 experienced a delay in opening a new program in a local middle school; the new target for opening is fall 2005. Both Weld School District 6 and Harrison School District 2 had not previously hosted school-based health centers.

In November 2004, voters passed Amendment 35 and the new law has several provisions that are expected to positively impact SBHCs.

The Colorado Association for School-Based Health Care produced a report for the 2003-2004 school year. Called "Healthy Kids Learn Better," it describes the services of Colorado school-based health centers in an attractive easy-to-read format. The document is provided as an attachment to this section.

c. Plan for the Coming Year

The revised FY 2006 target is 12.0 percent.

Activities described above will continue. Additionally, planning will be done to accommodate expected SBHC growth resulting from the tobacco tax initiative. The state health department will work with the state's Department of Health Care Policy and Financing to develop contracts. Protocols will be developed regarding eligibility status for funding, and quality assurance and reporting systems will be expanded.

State Performance Measure 8: *Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25.0	25.0	25.0	25.0	26
Annual Indicator	22.3	21.8	24.6	34.1	34.7
Numerator	49320	52775	63559	89350	105299
Denominator	221396	242260	258748	262321	303090
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	36	37	38	39

Notes - 2003

Data shown under 2003 are FY 03 data..

Notes - 2004

Data shown under 2004 are FY 04 data.

a. Last Year's Accomplishments

The 2004 target was 26.0 percent and 34.7 percent was achieved. The target was met.

The highest percentage of children served was in the El Paso and Teller County region with 44.7 percent; and the lowest was in Mesa County with 18.6 percent of Medicaid-eligible children receiving dental services. The continued success cannot be attributed to any one factor; however, increased awareness of the needs of Medicaid children among dental providers due to the exhibit at the Rocky Mountain Dental Convention; an increase in dental providers participating in the State Dental Loan Repayment Program; and an increase in dental Medicaid providers (571 in FY 2004 compared to 530 in FY 2003) all contributed.

As Medicaid data is shared only by regions, rather than individual counties, it is not possible to state how many counties are without dental providers. However, of the 20 regions categorized by Medicaid, all have at least four dental providers.

Twenty-four dental providers (six dental hygienists and 18 dentists) have participated in the State Dental Loan Repayment Program since its inception in 2001. A total of 45,318 underserved patients have been seen, including 14,691 Medicaid and 2,492 Child Health Plan Plus clients.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Developed a media campaign to raise awareness of the importance of oral health.			**X**	**X**
2. Worked to increase access to oral health services.	**X**	**X**	**X**	**X**
3. Developed a state oral health burden document to describe the status				

of oral health in Colorado.				X
4. Continued the State Dental Loan Repayment Program and other measures to increase access to oral health providers.	X	X	X	X
5. Participated in the development of a state oral health improvement plan.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 35.0 percent.

The target was revised to reflect an increase in the number of children served in FY 2004.

Activities previously described will continue.

The Oral Health Program conducted an oral health screening of 2,935 Head Start and Early Head Start children to establish baseline data on the oral health status of this population. Thirty-two percent of the children had untreated dental decay with seven percent of the children having dental decay in all four quadrants. Eighteen percent had a pattern of dental decay known as early childhood caries. The level of dental disease in Colorado's low-income preschool children is more than three times higher than the Healthy People 2010 objectives. The Oral Health Program is developing strategies for addressing the needs of very young children. Strategies include training general dental providers to treat children and encouraging parents to have their children's teeth checked by age one.

c. Plan for the Coming Year

The FY 2006 target is 36.0 percent.

The target for FY 2006 was revised based on the success of the past several years.

Through the State Oral Health Collaborative Systems funded by the Maternal and Child Health Bureau, work has been ongoing to link oral health with Early Child Care Systems and the Coordinated School Health project. Funding is being provided to the Summit County School District to incorporate oral health activities into their Coordinated School Health scope of work. The district is providing school oral health screenings and sealants, books with stories about oral health for their libraries, and classroom education to grades 1 and 2.

State Performance Measure 10: *The rate of homicides among teens 15-19*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	5.5	5.5	5.5	5.5	5.0
Annual Indicator	9.7	4.9	8.0	5.6	5.6
Numerator	30	15	26	19	19
Denominator	309914	309222	325922	337039	341560
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.3	3.9	3.5	3	2.9

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2003 are for calendar 2002.

Notes - 2004

Data shown under 2004 are from calendar year 2003.

a. Last Year's Accomplishments

The FY 2004 target was 5.0 homicide deaths per 100,000 teens age 15-19 and 5.6 was achieved. The target was not met.

Nineteen adolescents died by homicide in 2003. To meet the 2003 goal, the number should have been 17 or fewer.

Homicide rates appear to be directly tied to gun violence, and in the decade of the 1990s, half or more of all teen homicides were by firearms. Out of the 19 deaths in 2003, 16 were by firearms.

The Prevention Services Division began FY 2004 without specific funding to address youth violence. In December 2003, the Governor's Office decided to allocate $4 million from the Jobs and Growth Tax Relief Reconciliation Act of 2003 to the division to fund youth service programs through June 2004. The one-time funding allowed the division to fund 105 community-based programs that target youth and their families for prevention and intervention strategies to reduce youth crime, violence, and other high-risk behaviors. The programs included student dropout prevention programs, early childhood, youth mentoring, and other programs designed to support children and youth to reduce negative outcomes. These were programs previously selected to receive Tony Grampsas Youth Services Program dollars before the funding was vetoed due to the state budget shortfall.

The Injury and Suicide Prevention Section of the Prevention Services Division received a 5-year grant from CDC in January 2004 to participate in the National Violent Death Reporting System. Detailed data will be available, linked between death certificates and medical examiner, police, and coroner reports. We anticipate that the information gained from this system will help us develop interventions in the future to reduce homicide.

School-based health centers also address the issue of violence among students in middle and high schools. Physical exams provided by the centers include a comprehensive health history

and a student-completed history containing several questions about exposure to or involvement in aggressive behavior. The health care practitioner reviews the survey with the student to develop a plan for addressing the risk. Because behavioral health services are provided in school-based health centers, referrals for care are readily completed.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed and implemented strategies for creating safe and drug-free schools.			X	
2. Developed and implemented strategies for promoting healthy childhood development.			X	
3. Supported SBHCs and their emphasis on mental health as appropriate avenues toward reducing teen violence.	X	X	X	X
4. Supported anti-bullying programs through the schools.				X
5. Participated in National Violent Death Reporting System with the goal of developing interventions to reduce homicide.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 4.3 per 100,000 teens.

The Tony Grampsas Youth Services Program received $3.4 million in state Tobacco Master Settlement funds to support its 105 programs during state fiscal year 2005, which began July 1, 2004. A Program Director was hired in October 2004.

The Colorado Department of Public Health and Environment received an $85,384 grant to improve the health of Colorado's children and adolescents by preventing violence. Colorado is one of eight states to receive funding from the Centers for Disease Control and Prevention for a two-year program that will work to support change in societal norms and environmental conditions contributing to violence. The program, which is housed in the Injury and Suicide Prevention Program, is a collaborative effort between the department's Injury Section and the Child, Adolescent and School Health Section. The funding is to be used to develop a strategic plan to address shared risk and protective factors for violence among children and youth. A Violence Prevention Advisory Group consisting of nationally known violence prevention experts, state agency leaders, and members of private and nonprofit prevention groups, was created. In year one of the project, a state report card will inventory the needs and available resources throughout the state, evaluate existing policies, identify state-level data sources, and determine readiness to commit to integrating prevention efforts.

c. Plan for the Coming Year

This performance measure has been discontinued, but work will continue in this area. The Tony Grampsas Youth Services Program anticipates receiving $3.4 million in state funding to

support its programs during state fiscal year 2006, which begins July 1, 2005. Also, in year two of the CDC Violence Prevention Grant, the Injury and Suicide Prevention Program and Child, Adolescent and School Health Section will develop a statewide strategic plan. The plan will outline strategies to address shared risk and protective factors among different types of violence. It will also incorporate recommended approaches that address personal, interpersonal, and environmental or social factors that will lead to the reduction of youth violence in Colorado.

State Performance Measure 12: *The proportion of WIC children who are obese*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			9.4	6.4	8.5
Annual Indicator	9.4	6.4	8.3	8.7	9.4
Numerator			2429	2860	4771
Denominator			29294	32878	50755
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.5	8.5	8.5	8.5	8.5

Notes - 2003

Data shown under the 2003 heading are calendar 2002 WIC program data.

Notes - 2004

Data shown under the 2004 heading are calendar year 2003 WIC program data.

a. Last Year's Accomplishments

The FY 2004 target was 8.5 percent and 9.4 percent was achieved. The target was not met.

This measure is based on children between the ages of 2 and 5 years old with weight for height greater than or equal to the 95th percentile.

The Colorado WIC Childhood Overweight Prevention Campaign continued to focus on families making the healthy switch to lower fat milk. Nine months after the rollout of the new lower fat milk standard food package for WIC participants, 48 percent of women and children 2-5 years of age who participated on the WIC program had switched to the lower fat milk food package. Local agency staff continued in the effort to educate families and to promote lower fat milk with the goal of 90 percent of women and children 2-5 years of age eventually receiving the lower fat milk food package.

Along with the promotion of this lower fat milk food package, local agency WIC staff started to

encourage and promote physical activity for children and families on a regular basis. These messages were in addition to nutrition messages that the WIC Program has always provided. In April 2004, WIC staff was trained using the Best Start 3-Step Counseling Strategy. This helped WIC staff to determine each participant's individual barrier to optimal health behavior and to address it in such a way as to encourage positive health choices.

In early FY 2004 WIC prepared a second annual summary paper for WIC professionals on childhood overweight and ideas to address the problem. Collaboration with the nutrition department at the University of Northern Colorado allowed nutrition students to use their creativity to contribute to the campaign. Students worked in groups to create information sheets focusing on juice consumption, fast food, activity, snacking, parental modeling of healthy behaviors, and portion control. These were used in creating educational materials with practical information to local agency staff to use with WIC participants/parents as a part of the Colorado WIC Childhood Overweight Prevention Campaign.

The Colorado WIC program continued to play a role in the Colorado Physical Activity and Nutrition (COPAN) Early Childhood Task Force and the Breastfeeding Task Force. Both groups are focused on creating tool kits that would help local communities begin efforts to promote breastfeeding, healthy food choices and behavior, and activity as obesity prevention measures. The Early Childhood Task Force took the lead in coordinating a statewide videoconference in October 2004. The videoconference was sponsored by MCH, promoted by JFK Partners and titled, "Preventing Childhood Obesity: Laying the Groundwork for Prevention." The videoconference drew over 130 participants from around the state and was very well received.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to train WIC staff around child nutrition and physical activity as obesity prevention measures.	X	X		X
2. Provided standardized lower fat milk food package to over 90 percent of participants.	X			
3. Developed educational materials for paraprofessional staff with practical information on pediatric overweight.				X
4. Partnered with the Colorado Physical Activity and Nutrition Task Force, the Early Childhood Task Force, and the Breastfeeding Task Force to reduce obesity among children.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 8.5 percent.

The Colorado WIC Childhood Overweight Prevention Campaign continues to focus on families making the healthy switch to lower fat milk. In January of 2005, many of the whole milk food packages that remained available to WIC participants were eliminated. The choice still

remained, but was limited. Results from this change have been a dramatic increase in the number of families receiving the lower fat milk food packages around the state, in excess of 90 percent, thus meeting the initial goal of 90 percent of women and children 2-5 years of age receiving the lower fat milk food package.

Along with the promotion of lower fat milk as a healthy choice, staff continue to promote physical activity as a part of a healthy lifestyle. Many local WIC agencies are promoting wellness among staff, with this translating into more practice-based health messages for participants.

In May 2005, the Colorado WIC program hosted a State WIC Meeting focused on motivating WIC staff to "practice what they preach" in terms of eating healthfully and exercising. The thought is that if WIC staff espouse good personal healthy habits, it will be easier for them to help participants make changes.

The Colorado WIC program continues to play a role in the Colorado Physical Activity and Nutrition Early Childhood Task Force and the Breastfeeding Task Force. Along with the release of tool kits, the task force had mini grants available for local communities. The mini grants were overwhelmingly well received and several community projects received funding of $1,000 for projects relating to breastfeeding promotion, healthy food choices and behavior, and activity such as obesity prevention measures. The Early Childhood Task Force created a list of best practice activities for obesity prevention in early childhood centers (child care/home care). The Breastfeeding Task Force worked on creating community and workplace environments that promote and support breastfeeding.

c. Plan for the Coming Year

This performance measure has been discontinued. It is being replaced by a measure of BMI among all children 2 to 14.

During FY 2006, WIC staff will continue work to promote healthy nutrition and activity choices for overweight and obesity prevention. Paraprofessional staff will receive materials with practical information to use with WIC parents, and professional staff will be updated with an annual summary paper on childhood overweight and ideas to address the epidemic.

State Performance Measure 13: *The percentage of women with inadequate weight gain during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		24	24	23	23
Annual Indicator	25.4	23.3	23.3	24.5	22.9
Numerator					
Denominator					
Is the Data					

Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	22.5	22.3	22	20.7	17.8

Notes - 2002

Data for 2002 are estimated using PRAMS data for 2000 (first reported in 2001).

Notes - 2003

Data shown under the 2003 heading are 2002 PRAMS data.

Notes - 2004

Data shown for 2004 are from the 2003 Pregnancy Risk Assessment Monitoring Survey.

a. Last Year's Accomplishments

The FY 2004 target was 23.0 percent and 22.9 percent was achieved. The target was met.

With the release of Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado in 2000, a long-term effort to reduce the incidence of inadequate weight gain during pregnancy was begun. One in four women fails to gain adequate weight during pregnancy, which has a significant impact on the number of low birth weight births. The report stated that the state low birth weight rate (among singleton births) could be reduced by nearly a full percentage point if all women gained weight adequately.

The Women's Health Section determined that a social marketing approach to the inadequate weight gain problem would have the greatest chance of success. The social marketing plan addressed provider training, outreach to key stakeholders, and the development of a Web site. The campaign was named "A Healthy Baby is Worth the Weight."

A limited provider outreach campaign was initiated. Outreach grants were awarded to six local health departments and Kaiser Permanente. Each agency identified someone within the agency to function as the campaign coordinator for the site. The desired outcomes for this project were for each coordinator to provide training to 100 prenatal health care providers (physicians, nurses, dietitians, and other agency support staff); and to strengthen clinical practice skills such as weight assessment, counseling, and documentation related to weight gain in at least 10 prenatal care provider settings. Additional goals included providing patient education materials and weight gain counseling to at least 500 pregnant women per grantee. Most agencies met their campaign goals. At the end of the grant period, a total of 845 health care professionals had received training and education, of which 275 were physicians or physician assistants and 319 were nursing professionals. Almost 5,000 brochures were distributed to providers' offices and pregnant women.

As part of the social marketing plan, outreach included collaboration with partners such as WIC, Prenatal Plus, Nurse Home Visitor/ Nurse Family Partnership, and March of Dimes. Several of these community partners had statewide or regional meetings in FY 2004 where a Women's Health Section staff person was invited to present about the campaign. Additional presentations or poster sessions for FY 2004 included the Colorado Nurse Practitioner Symposium, Public Health in the Rockies-Colorado Public Health Association, and the CityMatCH MCH Audio Conference.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Documented and provided data at state and local level about the impact of inadequate maternal weight gain.				X
2. Developed and implemented a social marketing campaign, "A Healthy Baby is Worth the Weight," to local health departments and private providers.			X	X
3. Continued successful Prenatal Plus Program among Medicaid clients targeting women at risk for poor birth outcome.		X		
4. Engaged in outreach and participated in training for prenatal care professionals.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target is 22.5 percent.

The Women's Health Section designed a consumer/provider friendly website with an easy to remember name: www.healthy-baby.org. Consumers are able to calculate personal BMI values and receive information on appropriate weight gain for their BMI category. A printable weight gain grid, patient education materials, and an "Ask the Dietitian" section are included. Additionally, prenatal care providers can access various reports and research publications; strategies to incorporate into their practices; community resources; and focus group findings used to develop the campaign materials and messages.

As part of the campaign's evaluation component, a new question was added to the PRAMS survey in January 2004 that asks pregnant women if they were told to gain a certain amount of weight by their health care providers, and if so how much. This information will help assess prenatal health care providers' weight gain recommendations. Information will be gathered through 2007.

Another PRAMS question probes if access to food is an issue in the household. The answers to these questions will help assess the extent of the weight gain campaign's success as measured by women knowing their BMI and how much weight to gain. It will also help assess the extent to which access to food is a barrier to adequate weight gain. The long-term plan to address inadequate weight gain during pregnancy will be informed and modified by these PRAMS data.

In October 2004, a statewide videoconference was held to provide training to six health departments (three of which had previously participated) that chose to locally implement components of the "A Healthy Baby is Worth the Weight" campaign.

Policy Studies Inc. was hired to create and test public service announcements with the campaign's target audiences for future media efforts. They also developed collateral materials to promote the campaign and the campaign Web site.

Presentations were made to the March of Dimes-Colorado Prematurity Summit, JKF Partners-

MCH Teleconference, Breastfeeding Educators Conference, the University of Colorado Health Sciences School of Nursing, and the National Association of Maternal and Child Health Programs Annual Meeting.

c. Plan for the Coming Year

The FY 2006 target is 22.3 percent.

A consumer media campaign will be launched by December 2005. It is expected that this will include newspaper or magazine articles or ads, radio spots, and TV ads.

Ongoing efforts to reach the physician and health care community will continue indefinitely and a mass mailing notifying providers of the upcoming media campaign will allow for additional training opportunities.

New consumer outreach activities may include emailing or direct mailing information to pregnant women enrolled in public and private health insurance plans about the importance of weight gain in pregnancy and providing them with information about the campaign Web site. The Program will explore the role of insurance providers in promoting adequate weight gain in pregnancy and determine the best ways to involve them in the campaign, possibly working to encourage insurance coverage for nutrition counseling.

Components of the campaign rollout are included within an MCH model goal and objective that the local health departments can select as part of their MCH activities for the year. Training and technical assistance will be provided to any health department planning to use MCH funding to directly target this measure during FY 2006.

The Colorado birth certificate will be updated in January 2006 and new questions about prepregnancy weight and height will be added. This should improve our ability to analyze adequate weight gain among all women in the state.

State Performance Measure 14: *The rate of injury hospitalization among children 19 and younger*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			280	271	300
Annual Indicator		319.8	321.8	303.5	279.7
Numerator		3935	4087	3923	3658
Denominator		1230455	1269907	1292626	1307764
Is the Data Provisional or Final?				Provisional	Final

	2005	2006	2007	2008	2009
Annual Performance Objective	270	250	245	240	235

Notes - 2002

Data shown under the year heading are from vital statistics data for the previous calendar year. For example, data shown for 2002 are for calendar 2001.

Notes - 2003

Data shown under the 2003 heading are from hospital discharge data for 2002.

Notes - 2004

Data shown under 2004 are from hospital discharge data for 2003.

a. Last Year's Accomplishments

The FY 2004 target was 300.0 hospitalizations per 100,000 youth and 279.7 per 100,000 was achieved. The target was met.

The number of injury hospitalizations was 3,658 among all children age 19 or younger, out of a population of 1,307,764 (calendar 2003 data). The rate the previous year, using 2002 data, had been 303.5. The 279.7 rate represents a nearly 8 percent decline from the previous year.

An analysis at the county level shows a wide variation in injury hospitalization rates. A total of 22 counties (using 1999-2003 data) met the 300.0 target rate, while the remaining 42 had higher rates, and four had rates that were double the target. However, this is an improvement over the previous year, when only eight counties met the target rate.

The Colorado legislature, responding to the fact that motor vehicle injury rates and deaths have remained high in the last two years, introduced several bills during the 2004 legislative session. HB 04-1017 was passed in May 2004, strengthening the existing Graduated Driver's Licensing law by increasing the age at which a teen driver can get a learner's permit from 15 and a half to 16 years (unless they have had a driver's training course). In addition, a learner's permit lasts for one year instead of the current six months. This law became effective on July 1, 2004.

The Injury and Suicide Prevention Program, with participation from the Child, Adolescent and School Health Section staff, continued to work with the Injury Prevention Advisory Committee of the State Emergency Medical and Trauma Services Advisory Council. Implementation of the state Injury Prevention Strategic Plan for 2003-2008 was undertaken, focusing on the target groups of hospital trauma centers, EMTs, Regional Emergency and Trauma Advisory Councils, and state and local public health staff. Further information is available at www.cdphe.state.co.us/em/SEMTAC/semtachom.htm.

A guide to the use of injury data, an injury epidemiology brief, was written in July 2004 and is attached to this section.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained website (www.cdphe.state.co.us/pp/cfrc/cfrchom.asp) through the Child Fatality Review Committee.		X	X	
2. Documented and provided data on a state and local level for injury				X

hospitalization.				
3. Implemented strategies from the state Injury Prevention Strategic Plan for 2003-2008.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FY 2005 target has been revised to 270.0 hospitalizations per 100,000 youth.

The Injury Epidemiology Program has updated the Injury in Colorado report, originally published in June 2002. The 2005 report is at www.cdphe.state.co.us/pp/injepi/InjuryinColorado/injuryincolorado.html. The comprehensive report provides information on injury in Colorado, including deaths, hospitalizations, and traumatic brain injury. A short two-page fact sheet, "The Burden of Injury in Colorado," was prepared in December 2004 and is attached to this section.

In June 2003, injury hospitalization data had been added to the Colorado Health Information Dataset (CoHID), which could only be queried by approved users. The CoHID password requirement was eliminated in February 2005 so that the information is accessible to all health data users.

SB 05-036 was passed in the 2005 legislative session. It limits the number of minor passengers in cars driven by teens during the first six months after receiving their drivers' licenses. Only siblings will be allowed as passengers during this time.

c. Plan for the Coming Year

This performance measure has been discontinued. However, injury prevention will continue to be addressed and counties will receive local data. This performance measure has been replaced by one monitoring the teen motor vehicle death rate.

E. OTHER PROGRAM ACTIVITIES

Toll-Free Hotline

The Family Healthline is a statewide information and referral service located at the Colorado Department of Public Health and Environment. During FY 2004, 8,501 calls were received by the Healthline resource specialist. The Healthline assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, mental health, or parenting support groups. The Healthline specialist speaks fluent Spanish and English, and arrangements are made for assisting the hearing- impaired and callers who speak other languages.

The Family Healthline specialist makes referrals, usually within each caller's own community, and can in certain instances establish a direct connection for the caller. Individuals often make repeat calls to the Healthline once they learn the extent of the referral database and the expertise of the staff. The

Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic violence counseling, and other basic subsistence resources.

The Family Healthline works closely with the Covering Kids and Families program and in some cases, assists individuals in completing the joint Medicaid/Child Health Plan Plus/Colorado Indigent Care Program application form.

Each Healthline call is recorded in a database where demographic and other call information is stored. Monthly reports are generated that detail certain caller demographics (place of residence, Spanish-speaking, etc.) and purpose of the call (Medicaid assistance, immunizations, etc.). These data are useful for program planning efforts. The database software has the capacity to track whether a call is the result of a specific state or national campaign effort. Using the database, the Healthline specialist can refer back to the original call for greater efficiency and better customer service. The database is also used to prepare summary reports.

Sudden Infant Death Program

The Colorado Sudden Infant Death Program is a statewide non-profit 501(c) 3 organization. The program's primary purpose is to provide early intervention through information and counseling to those persons affected by the sudden death of an infant. The program assures that emergency and other first responders understand SIDS and are able to provide accurate and appropriate information and referral resources to the family. Program staff provide the majority of the services to parents, relatives, friends, day care providers, and others. They are assisted by a statewide network of public health nurses, parents, and volunteers.

In FY 2004, the program received 60 information referrals on infant deaths of which 45 were reported as SIDS deaths. Within 48 hours of notification, each family and child care provider was contacted and mailed literature. Every family for whom the program has contact information receives scheduled mailings through the second anniversary of their infant's date of birth.

Over 1,289 contacts (phone and letters) were made in FY 2004. Educational presentations were provided to 248 individuals that included victim advocates, law enforcement officers, health care providers, social services staff, and coroners.

The program held 33 presentations in FY 2004 that offered general and risk reduction information related to SIDS. The presentations reached 727 individuals that included child care providers, new parents, child birth educators, and the general community.

Risk reduction information is also offered through newsletters, health fairs, and in targeted locations such as stores catering to babies.

F. TECHNICAL ASSISTANCE

Colorado's technical assistance needs are shown on Form 15. The program is seeking assistance as shown below.

Consultation is requested to clarify HIPAA regulations and the sharing of data between the state Medicaid agency and the state health department. We are at this time unable to obtain data we consider necessary for assessing the health status of the maternal and child health population.

We would also like consultation on how to best estimate the number of children potentially eligible for Medicaid. Calculation of the number is problematic and complex. A 2005 effort using CPS data and other sources did not result in a satisfactory answer.

Assistance in developing a system to determine prevalence of dental sealants among school aged

children during the intervening years is also requested. This information is now collected only every five years, but estimates are needed for the intervening years.

Consultation is also requested about how to reduce late entry into prenatal care, especially considering the fact that a number of women do not have access to health insurance.

V. BUDGET NARRATIVE

A. EXPENDITURES

Information on annual expenditures is contained in Form 3, Form 4, and Form 5. Some noticeable shifts are apparent between FY 2003 and FY 2004, as funds were moved to infrastructure activities, decreasing the amount utilized for direct health care services (Form 5). Although the Federal-State MCH funding decreased 2.5%, funding stayed proportionately level for each of the MCH populations served. (Form 4).

Form 3
Total expenditures in FY 2004 were 3.5% lower than those budgeted for the year. The federal allocation was $276,828 lower than budgeted ($7,880,181 vs. $7,603,353); and the required match was $207,621 lower than budgeted ($5,910,136 vs. $5,702,515).

FY 2005 application inaccurately reported FY 2003 expended State and Local MCH Funds. State Funds of $1,411,007 were erroneously reported as Local MCH Funds. The total expended State and Local MCH Funds remain unchanged for FY 2003.

Form 4
Total expenditures in FY 2004 for pregnant women amounted to $2.81 million and nearly equal to the $2.84 million budgeted. Expenditures for children age 1 to 22 amounted to $3.96 million and below the $4.77 million that had been budgeted. Expenditures for children with special health care needs amounted to $5.58 million; above the $5.27 million budgeted.

Local match from local health departments was originally budgeted ONLY in categories "Pregnant Women" and "Children 1 to 22 years old." Actual local match reported by local health departments was mainly from the category "Children with Special Health Care Needs".

Form 5
Expenditures for infrastructure services substantially increased from $4.0 million budgeted to $4.8 million expended. Direct health care services substantially decreased from $2.1 million budgeted to $1.16 million expended. Enabling services were increased from $3.88 million budgeted to $4.1 million expended. Population-based expenditures were decreased from $3.7 million budgeted to $3.18 million expended.

Colorado's local health departments' local match expenditures are moving from direct health care to enabling and infrastructure services. Population-based services have been emphasized in FY 2004 at the State level in order to build capacity at the local level for FY 2005 and FY 2006.

B. BUDGET

Budget information is contained in Forms 2, 3, 4, 5, and 10.

Form 2 shows the federal allocation as $7,569,141 for FY 2006. Of these dollars, a total of 33.62 percent will be allocated for preventive and primary care for children, 32.47 percent will be allocated for children with special health care needs, and 9.74 percent will be spent on administration. These proportions meet the MCH Block grant requirements.

In addition, the form shows state funds of $4,736,061 and local funds of $940,795, meeting the requirement that the total amount, $5,676,856, must equal three-fourths of the federal allocation. The state maintenance of effort from 1989 is $4,736,061. The total state match for FY 06 is $4,736,061, which is the same amount.

The total state match consists of state general funds in the amount of $3,369,105 and cash funds in

the amount of $1,366,956 (genetics counseling fees and Colorado Children's Trust Fund). Local funds that support prenatal and child health activities conducted at local health departments total $940,795.

Under Other Federal Funds, the CISS grant line (Form 2, line 9.c.) is the State Early Childhood Comprehensive System Grant.

Centers for Disease Control (Form 2, line 9.i.) funds include $175,000 for Early Hearing Detection and Intervention (EHDI) Tracking, Research and Integration with Other Newborn Screening Programs Grant; $238,986 for National Violent Death Registry Grant; $85,383 for Enhancing State Capacity to Address Child & Adolescent Health through Violence Prevention Grant; $631,943 for Rape Prevention and Education Grant; $275,374 for Motor Vehicle Injury Grant; and $4,578,542 for NBCCEDP: National Cancer Prevention and Control Program, National Breast and Cervical Cancer Early Detection Program. A number of program changes have taken place, including placement of the Injury and Suicide Prevention Section and the Women's Health Sections under the administration of the MCH Director.

Under "Other" (Form 2, line 9.k.) the program received $394,924 for Community-Based Child Abuse Programs, money that is received from the Administration for Children and Families, Office of Child Abuse and Neglect; $300,000 of MCHB funds for the ISNSS (Promoting Integration of State Health Systems and Newborn Screening Services Systems for Monitoring and Ensuring Quality Services to Newborns and Children with or at Risk for Heritable Disorders); and $3,089,906 of Title X funds.

The Federal-State Block Grant Partnership total on Form 2 equals $13,245,997, and the State MCH Budget Total, shown at the bottom of the form, equals $23,216,756.

Form 4 reflects the shift in Local MCH funds from pregnant women to children with special health care needs.

Form 5 reveals the emphasis on infrastructure activities in FY 2006: planning, evaluation, and needs assessment, with special attention to monitoring and technical assistance for local programs.

Assurances:
The Colorado Department of Public Health and Environment will spend these funds as they are presented in this application.

The Colorado Department of Public Health and Environment uses a funding formula based on the number of children and women of childbearing age as well as on the number of low-income children and women of childbearing age to distribute the majority of available funding. However, some funds are distributed in compliance with Colorado's Procurement Rules and involve either a Request for Award process, e.g. social marketing, or Sole Source Justification process, e.g. SIDS funding.

The department will only use these funds to carry out the purposes of Title V.

The department publishes sliding-fee schedules for all services for which charges are made. Charges will not be imposed on low income mothers and children, and will be adjusted to reflect the income, resources, and family size of individuals.

Department grantee audits are performed every two years, except when the grantee falls under the Single Audit Act provisions of Federal law.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.